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# ROYAL COMMISSION ON HEALTH SERVICES

## HEARINGS

HELD AT

HALIFAX

N. S.

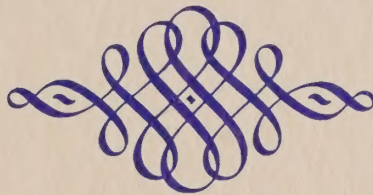
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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing held  
at Halifax, Tuesday, October 31st,  
1961.

COMMISSION MEMBERS:

Chief Justice EMMETT H. HALL -- Chairman

Miss ALICE GIRARD, R.N.

Mr. DAVID M. BALTZAN

Prof. O.J. FIRESTONE

Mr. M. WALLACE McCUTCHEON, Q.C.

Dr. C.L. STRACHAN

Dr. ARTHUR F. VAN WART

COMMISSION COUNSEL:

Mr. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

Dr. PIERRE JOBIN

DIRECTOR OF RESEARCH:

Prof. BERNARD BLISHEN

SECRETARY:

Maj. N. LAFRANCE



Proceedings of the hearing held

Chief Justice ROBERT H. HALL

Miss ALICE GIBARD, R.N.

PROV. O.J. FIRESTONE

MR. W. WALLACE MONTGOMERY, D.C.

DR. G.L. STRACHAN

MR. ARTHUR T. VAN WAT

EXHIBIT COURTESY:

MR. A.M. HALL, D.C.

LEGAL COUNSEL:

INSPECTOR OF INVESTIGATION:

MR. BERNARD BLISS





Halifax, Nova Scotia,  
Tuesday, October 31st, 1961

--- On commencing at 9.30 a.m.

THE SECRETARY: Exhibit No. 7, submission of  
the Medical Society of Nova Scotia.

--- EXHIBIT NO. 7: Submission of the Medical Society of  
Nova Scotia.

THE CHAIRMAN: Ladies and gentlemen, we will  
come to order and proceed from where we left off yesterday  
afternoon. It was the situation that these distinguished  
gentlemen here were ready to answer any questions that  
might be put to them.

Commissioner Firestone?

COMMISSIONER FIRESTONE: Mr. Chairman, I  
would like to address my questions largely to Dr. Ross.  
He is welcome, of course, to ask any of his associates  
to deal with them. I would like to start off first by  
reading to you, part of a sentence contained in the brief  
of the Government of Nova Scotia, submitted to us yester-  
day, and that statement read as follows: "The proposals  
which the Government of Nova Scotia are submitting to the  
Royal Commission are based on the premise that access to  
all health services necessary to maintain normal health  
should be available to every citizen of Canada". That was  
one statement. The second statement was made by the  
Chairman of this Royal Commission in our preliminary  
hearing in Ottawa. If I may just refresh your memory: "In  
the stage of economic and social development which Canada







1 has reached, as is the case in many other western countries,  
2 the desire for good health has become universal. The view  
3 appears to be developing, taken into account increasingly  
4 by Government, that the opportunity for good health is the  
5 right possessed by all, and should become available in one  
6 form or another to every citizen in Canada". Now, sir,  
7 may I ask you this question. Does the Medical Society of  
8 Nova Scotia subscribe to this principle, as has been  
9 expressed by the Government of Nova Scotia, and indicated  
10 in the opening statement of our Chairman?

11 DR. ROSS: Absolutely.

12 COMMISSIONER FIRESTONE: The answer is yes?

13 DR. ROSS: Yes.

14 COMMISSIONER FIRESTONE: Now, if I may pro-  
15 ceed from here. We are therefore talking about the provi-  
16 sion of a health services program for all people in Canada  
17 on a comprehensive and universal basis, is that correct sir?

18 DR. ROSS: Would you repeat the question  
19 please.

20 COMMISSIONER FIRESTONE: Are we therefore  
21 talking about a health services program that is comprehen-  
22 sive, and covers all the citizens of Canada?

23 DR. ROSS: Of course, our brief is referring  
24 to our own Province, but it could be applicable to the  
25 whole of Canada.

26 COMMISSIONER FIRESTONE: Can I rephrase the  
27 question, and say are we talking about a comprehensive  
28 medical services program covering all the citizens of the  
29 Province of Nova Scotia?

30 DR. ROSS: Of course that is the plan. The



the desire for good health has become universal. The view  
of the medical profession, however, has been somewhat  
different. It has been the desire of the medical profession  
to have a health service for all, but not necessarily  
for all at once.

form or another to every citizen in Canada". Now, sir,  
may I ask you this question. Does the Medical Society of  
Nova Scotia subscribe to this principle, as has been

COMMISSIONER FIRSTONE: The answer is yes?

DR. ROSS: Yes.

COMMISSIONER FIRSTONE: Now, if I may pro-

ceed from here. We are therefore talking about the provi-  
sion of a health services program for all people in Canada  
on a comprehensive and universal basis, is that correct sir?

DR. ROSS: Would you repeat the question

COMMISSIONER FIRSTONE: Are we therefore

talking about a health services program that is comprehen-  
sive, and covers all the citizens of Canada?

DR. ROSS: Of course, our belief is referring

to our own province, but it could be applicable to the

whole of Canada.

COMMISSIONER FIRSTONE: Can I rephrase the

question, and say we are talking about a comprehensive  
medical services program covering all the citizens of the

province of Nova Scotia?

DR. ROSS: Of course that is the plan. The





1 understanding is that the citizens who cannot afford it  
2 shall be assisted. The ones that can afford it shall  
3 have a plan offered that will suit them.

4 COMMISSIONER FIRESTONE: But the scheme  
5 would cover all the citizens of the Province of Nova Scotia,  
6 and would therefore be comprehensive?

7 DR. ROSS: Oh, yes.

8 COMMISSIONER FIRESTONE: Thank you very much.  
9 Now, the next question is that we were hearing yesterday  
10 from Dean Stewart that it may take something like 10 to 15  
11 years to develop the health personnel, and particularly  
12 physicians, to provide a substantial increase in the  
13 health services for the people of Nova Scotia. Can we  
14 have your views, sir, as to whether you feel that it would  
15 take 10 to 15 years to achieve a substantial improvement  
16 in health services, or whether perhaps something could be  
17 done more quickly in a perhaps shorter period of time,  
18 and if you find this question is too difficult to answer  
19 without further consideration, would you and your group  
20 be prepared to make a supplementary submission to the  
21 Royal Commission dealing with this question?

22 DR. ROSS: Yes, I think we would. It is a  
23 matter for study. It is not really our, we don't know  
24 enough about that, it would be a matter for the University  
25 authorities.

26 DR. GIFFIN: Mr. Chairman, may I add at this  
27 point we think we have covered this in our priorities  
28 under point K and in our summary we say that we emphasize  
29 that any one element should not be so covered and that the  
30 approval should be on a broad front.



COMMISSIONER FIRESTONE: But the scheme

would cover all the citizens of the Province of Nova Scotia

and would therefore be comprehensive?

COMMISSIONER FIRESTONE: Thank you very much.

Now, the next question is that we were hearing yesterday

from Dean Stewart that it may take something like 10 to 15

years to develop the health personnel, and particularly

physicians, to provide a substantial increase in the

health services for the people of Nova Scotia. Can we

have your views, sir, as to whether you feel that it would

take 10 to 15 years to achieve a substantial improvement

in health services, or whether perhaps something could be

done more quickly?

And if not, what is the reason for the delay?

What is the main reason for the delay?

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1 It is not our view that you cannot have  
2 improvements for 10 or 15 years. The improvements in  
3 some of our recommendations could be put into effect very  
4 promptly.

5 COMMISSIONER FIRESTONE: This is very  
6 helpful, Doctor, and perhaps we can have an indication  
7 from you of some of the things that can be done in the  
8 somewhat near future, rather than having to wait for a  
9 substantial improvement for 10 to 15 years?

10 DR. GIFFIN: We think that the provision of  
11 community health centres, the hospitals, these are the  
12 physical facilities, and perhaps the coverage for these  
13 medically indigent does not need a great deal of time,  
14 perhaps Dr. Beckwith could carry this thought on.

15 DR. BECKWITH: I don't think that there is  
16 any doubt at the present time the public of Nova Scotia is  
17 receiving good medical service. We want to see better  
18 medical service. On that basis then we have approached  
19 this, not only directly as in the brief, but also from an  
20 angle, insofar as we have sent out a community medical  
21 manpower questionnaire to no less than 90 doctors for  
22 details of the medical services in their community,  
23 including hospital service and so on, and the answers to  
24 this are regretfully not available. It is almost complete,  
25 but we will have it in the next month or so and be able to  
26 report on it. In Nova Scotia the suggestion of a community  
27 health centre for areas that will be selected as a result  
28 of requiring medical services is a very useful suggestion,  
29 and we believe one that can be developed in the very near  
30 future for the purpose of improving the medical services



It is not our view that you cannot have

improvements for 10 or 15 years. The improvements in

some of our recommendations could be put into effect very

promptly.

COMMISSIONER FIRESTONE: This is very

helpful, Doctor, and perhaps we can have an indication

from you of some of the things that can be done in the

somewhat near future, rather than having to wait for a

substantial improvement for 10 to 15 years?

DR. GUTHRIE: We think that the provision of

community health centres, the hospitals, these are the

physical facilities, and perhaps the coverage for these

facilities.

perhaps Dr. Beckwith could carry this thought on.

DR. BECKWITH: I don't think that there is

any doubt at the present time the public of Nova Scotia is

receiving good medical service. We want to see better

medical service. On that basis then we have approached

the problem of medical service in Nova Scotia.

and, insofar as we have sent out a community medical

manpower questionnaire to no less than 90 doctors for

the purpose of ascertaining the needs of the community.

including hospital service and so on, and the answers to

this are regrettably not available. It is almost complete

but we will have it in the next month or so and be able to

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medical service for areas that will be selected as a result

of needing medical services is a very useful suggestion.

and we believe one that can be developed in the very near

future for the purpose of improving the medical services





1 to the rural communities. Complementary to that, we have  
2 also sent out a questionnaire to 21 communities in which  
3 one to two members of households are asked to answer these  
4 questionnaires, and from this we expect to get the answer  
5 from the public themselves as to the medical services  
6 they get, and how best to remedy them, and these two  
7 questionnaires, we believe, will give considerable additio-  
8 nal information. There is no doubt in my mind, and there  
9 is no doubt in the Medical Society's mind that medical  
10 services can be improved insofar as quantity is concerned,  
11 and quality insofar as the dispersement is concerned,  
12 provided we have some of the personnel and some of the  
13 facilities to further extend the medical manpower that we  
14 have.

15 COMMISSIONER FIRESTONE: I take it from what  
16 you said that there are certain surveys under way that  
17 when you have the records of the surveys you will be able  
18 to let us have supplementary information, and that in  
19 providing that supplementary information you will make  
20 reference to the types of services you will be able to  
21 extend in specific proposals in the next few years, so  
22 that we won't have to wait 10 or 15 years?

23 DR. BECKWITH: That is right.

24 COMMISSIONER FIRESTONE: If we are going to  
25 get a supplementary proposal from you, would it be possible  
26 to add up all the financial implications of the recommenda-  
27 tions contained in your report, and say that in order to  
28 implement these recommendations it would involve a total  
29 expenditure over a period of so many years of so-and-so  
30 many millions of dollars, and that in your opinion these



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COMMISSIONER FIRSTONE: I take it from what  
you said that there are certain avenues under way that  
to let us have supplementary information, and that in  
providing that supplementary information you will make  
reference to the types of services you will be able to  
extend in specific proposals in the next few years, so  
that we won't have to wait 10 or 15 years?  
DR. BROWN: That is right.

COMMISSIONER FIRSTONE: If we are going to  
get a supplementary proposal from you, would it be possible  
to add up all the financial implications of the recommendations  
contained in your report, and say that in order to  
implement these recommendations it would involve a total  
expenditure over a period of so many years of so-and-so  
millions of dollars, and that in your opinion these





1 expenditures should be financed in such-and-such a way?

2 Would it be possible for you to supply this information  
3 with the supplementary brief?

4 DR. GIFFIN: We could endeavour to do that.

5 There are certain intangibles, and one would be under  
6 mental health services. It would be most difficult to  
7 put into dollars and cents, because you don't know how fast  
8 or how far the reform of these services would go. Perhaps  
9 Dr. Jones would speak on that.

10 DR. JONES: I think that this is an exceed-  
11 ingly important point. What we have actually done as  
12 far as mental health services is to ask for a new pattern  
13 of care, and I would point out with respect to the Commis-  
14 sion, that one of the exceedingly important things in the  
15 mental health field, and after all, this is a field that  
16 occupies about half the hospital beds of this country,  
17 is the fact that throughout the world new patterns are  
18 being developed. Those patterns are moving away from the  
19 present institutions, moving into the community and the  
20 general hospital, and I am sure you know that last year  
21 over 40% of the first admissions of psychiatric patients  
22 in Canada were in general hospitals. They are moving into  
23 the offices of the general practitioners, psychiatrists,  
24 interns and so on, and because of this very great change  
25 in pattern it is awfully difficult to estimate what the  
26 costs are going to be. I myself would hope that we are  
27 not going to build more institutions, and get away from  
28 bricks and mortar, and that the cost of giving a very  
29 much improved mental health service would not be stag-  
30 geringly large.

1 experiments should be financed in such-and-such a way?  
2 Would it be possible for you to supply this information

3  
4 DR. WITKIN: We could endeavor to do that.

5 There are certain handicaps, and one would be under  
6 mental health services. It would be most difficult to  
7 put into dollars and cents, because you don't know how far  
8 or how far the reform of these services would go.

9 Dr. Jones would speak on that.

10 DR. JONES: I think that this is an exceedingly

11 ingly important point. What we have actually done as  
12 far as mental health services is to ask for a new system  
13 of care, and I would point out with respect to the Commission,  
14 that one of the exceedingly important things in the  
15 mental health field, and after all, this is a field that  
16 occupies about half the hospital beds of this country,

17 is the fact that throughout the world new patterns are  
18 being developed. These patterns are moving away from the  
19 present institutions, moving into the community and the  
20 general hospital, and I am sure you know that last year  
21 over 10% of the first admissions of psychiatric patients  
22 in Canada were in general hospitals. That is moving into  
23 the offices of the general practitioners, psychiatrists,  
24 into the and so on, and because of this very great change  
25 in pattern it is really difficult to estimate what the  
26 costs are going to be. I myself would hope that we are  
27 not going to build more institutions, and get away from  
28 white and mortar, and that the cost of giving a very  
29 approved mental health service would not be staggeringly





1 expenditures should be financed in such-and-such a way?

2 Would it be possible for you to supply this information  
3 with the supplementary brief?

4 DR. GIFFIN: We could endeavour to do that.

5 There are certain intangibles, and one would be under  
6 mental health services. It would be most difficult to  
7 put into dollars and cents, because you don't know how fast  
8 or how far the reform of these services would go. Perhaps  
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10 DR. JONES: I think that this is an exceed-  
11 ingly important point. What we have actually done as  
12 far as mental health services is to ask for a new pattern  
13 of care, and I would point out with respect to the Commis-  
14 sion, that one of the exceedingly important things in the  
15 mental health field, and after all, this is a field that  
16 occupies about half the hospital beds of this country,  
17 is the fact that throughout the world new patterns are  
18 being developed. Those patterns are moving away from the  
19 present institutions, moving into the community and the  
20 general hospital, and I am sure you know that last year  
21 over 40% of the first admissions of psychiatric patients  
22 in Canada were in general hospitals. They are moving into  
23 the offices of the general practitioners, psychiatrists,  
24 interns and so on, and because of this very great change  
25 in pattern it is awfully difficult to estimate what the  
26 costs are going to be. I myself would hope that we are  
27 not going to build more institutions, and get away from  
28 bricks and mortar, and that the cost of giving a very  
29 much improved mental health service would not be stag-  
30 geringly large.



1 expanded... should be... in such-and-such a way?  
2 would it be possible for you to supply this information

3 the supplementary price?

4 DR. GILKIN: We could answer you as to that.

5 mental health services. It would be most difficult to  
6 out into dollars and cents, because you don't know how far  
7 or how far the reform of these services would go. Perhaps  
8 Mr. Jones would speak on that.

9 DR. JONES: I think that this is an exceed-

10 ingly important point. What we have actually done as  
11 for as mental health services is to ask for a new pattern  
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13 tion, that one of the exceedingly important things in the  
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15 countries about half the hospital beds of this country,  
16 is the fact that throughout the world new patterns are  
17 being developed. These patterns are moving away from the  
18 present institutions, moving into the community and the  
19 general hospital, and I am sure you know that last year  
20 over 40% of the first admissions of psychiatric patients  
21 in Canada were in general hospitals. They are moving into  
22 the offices of the general practitioners, generalists,  
23 interns and so on, and because of this very great change  
24 in pattern is a serious difficulty to estimate what the  
25 costs are going to be. I agree with you that we are  
26 not going to build more institutions, and get away from  
27 them and more, and that the cost of giving a very  
28 much improved mental health service would not be great.





1 COMMISSIONER FIRESTONE: I take it from what  
2 you said your group would be able to provide us with esti-  
3 mates in the areas where they can reasonably be made, and  
4 in the field of mental health we would like some guidance  
5 of what the doctors themselves believe and your proposals  
6 and the financial implications. We understand there are  
7 various ways in which you can go about dealing with the  
8 problem, and we would like to have your views and the  
9 financial implications.

10 DR. BECKWITH: One of the major recommenda-  
11 tions we have made in the mental health field is the idea  
12 that psychiatric illness should be insured in the same way  
13 as any other illness. We don't have very good figures on  
14 this, but there are a pile of projects going on. There is  
15 one in New York City under the group of medical services  
16 there, where all psychiatric illness is insured. There is  
17 one in West Berlin. There is another one in Dallas, Texas.  
18 There is information, and we are not in a very good posi-  
19 tion to gather it, but it could be gathered and lead to  
20 some reasonable estimate.

21 COMMISSIONER FIRESTONE: I take it that we  
22 will still get a complete proposal of what some of the  
23 things are you recommend the Commission should be consi-  
24 dering, because if we don't get these proposals from the  
25 doctors, where should we get them from? The remainder of  
26 my questions are of two types. One has to deal with a  
27 few questions that result from your brief, and the second  
28 type of question, Dr. Ross, will be dealing with the prin-  
29 ciples which we understand your Society follows, and they  
30 are the same principles that have been submitted to us by

MR. FIRSTMAN: I take it from

I your group would be able to provide us with statistics in the areas where they can reasonably be made, and in the field of mental health we would like some guidance of what the doctors themselves believe and your proposals and the financial implications. We understand there are various ways in which you can go about dealing with the problem, and we would like to have your views and the financial implications.

One of the major recommendations that we have made in the mental health field is the idea that psychiatric illness should be treated in the same way as any other illness. We don't have very good figures on this, but there are a pile of projects going on. There is one in New York City under the name of medical services where all psychiatric illness is insured. There is some information, and we are not in a very good position to gather it, but it could be gathered and lead to some reasonable estimate.

COMMISSIONER FIRSTMAN: I take it that we

dealing, because if we don't get these proposals from the doctors, where should we get them from? The remainder of my questions are of two types. One has to deal with a

type of question, Mr. Rose, will be dealing with the question which we understand your Secretary follows, and they are the same principles that have been submitted to us by





1 the Canadian Medical Association. If I may proceed first  
2 with the questioning following the outline of your submis-  
3 sion.

4 My first question relates to paragraph 16  
5 on page 4 at the very bottom. It really starts on page 3,  
6 the bottom, and then ends on page 4, the top. Dr. Ross,  
7 you speak of about 100,000 of Nova Scotia citizens may be  
8 classified as indigent, and the total cost of such services  
9 be paid from public funds. You go on and say for those  
10 above this level of economic status, who can prove need,  
11 we suggest that assistance be provided to enable them to  
12 purchase the coverage which they require. You use the  
13 phrase: "Those who can prove need". Is your Association  
14 recommending a means test?

15 DR. GIFFIN: We do not make any direct  
16 recommendation of that nature, Mr. Chairman, but I think  
17 it is implied. Actually, these 100,000 are really defined  
18 by a means test. The provision of drugs, say to the dia-  
19 betic, is a means test. Income tax is a means test, and  
20 one method of identifying these people who are not completely  
21 indigent, in other words, those who do not receive assis-  
22 tance from the Government, but who are not able to pay  
23 their major medical and surgical expenses, the income tax  
24 returns would be very helpful in defining.

25 COMMISSIONER FIRESTONE: I didn't hear the  
26 last half of your sentence.

27 DR. GIFFIN: I think that what I was saying,  
28 Mr. Chairman, was that in the identification of these  
29 people who cannot afford disastrous illness, that one  
30 method of identifying them is through the statistics on



GILPIN

association. If I may proceed first

My first question related to paragraph 10

on page 4 at the very bottom. It really starts on page 3,

the bottom, and then ends on page 4, the top. Dr. Ross,

you speak of about 100,000 of Nova Scotia citizens who do

classified as indigent, and the total cost of their hospital

care is about \$100,000. Is that correct?

above this level of economic status, who can prove need,

we suggest that assistance be provided to enable them to

purchase the coverage which they require. You use the

phrase: "Those who can prove need." Is your Association

recommending a means test?

Dr. Gilpin: We do not make any direct

recommendation. We are simply pointing out that the

present system is not working and that a change is

needed. We are not recommending a means test, and

better, in a means test. Income tax is a means test, and

one method of identifying these people who are not completely

indigent, in other words, those who do not receive assis-

tance from the Government, but who are not able to pay

their major medical and surgical expenses, the income tax

returns would be very helpful in defining.

COMMISSIONER KIRKWOOD: I didn't hear the

last half of your sentence.

Dr. Gilpin: I think that what I was saying,

Mr. Chairman, was that in the identification of these

people who are not completely indigent, the income tax

method of identifying them is through the statistics on





1 income tax, taking the average family in Nova Scotia as  
2 four.

3 COMMISSIONER FIRESTONE: I take it that from  
4 what you said that implied in the phrase: "Who can prove  
5 the need", is the implication of a means test, because you  
6 are using the phrase "prove"?

7 DR. GIFFIN: I would put it this way, that  
8 there is an implied financial need, and there should be  
9 some method of identifying them, and I am suggesting that  
10 they could be identified on the basis of the income tax  
11 returns.

12 COMMISSIONER FIRESTONE: Are you then sugges-  
13 ting that you would take an arbitrary figure and say that  
14 no one beyond a certain income level would be considered  
15 as being in need, and others, above a certain income level,  
16 would be considered as not being in need?

17 DR. GIFFIN: This takes us into a field in  
18 which we are not expert, and it is just one of the ideas  
19 that occurred to us. We know that we are deficient in  
20 using that method in that the income tax does not always  
21 reveal real worth, and I am thinking of the fisherman who  
22 does not file an income tax return, and because he has a  
23 cow and a small farm, his real worth is not indicated by  
24 the fact that he does not pay income tax.

25 COMMISSIONER FIRESTONE: It would be possible  
26 for you, if you are not quite sure what the phrase: "Those  
27 who can prove real need", or how this phrase can be put  
28 into practical application, that we might hear from you  
29 in your supplementary brief how this can be put into prac-  
30 tice. After all, we, as a Royal Commission, would like

1 income tax, taking the average family in Nova Scotia as

2 four.

3 COMMISSIONER FISHBURN: I take it that from

4 what you said that would be the process. Who can prove

5 the need, is the legislation means best, because you

6 Mr. GIBBON: I would put it this way, that

7 there is an implied financial need, and there should be

8 some method of identifying them, and I am suggesting that

9 they could be identified on the basis of the income tax

10 returns.

11 COMMISSIONER FISHBURN: Are you then sug-

12 gesting that you would take an arbitrary figure and say that

13 as one beyond a certain income level would be considered

14 as being in need, and others, above a certain income level,

15 would be considered as not being in need?

16 Mr. GIBBON: That takes us into a field in

17 which we are not experts, and it is just one of the ideas

18 that occurred to me. We know that we are deficient in

19 using that method in that the income tax does not always

20 reveal real worth, and I am thinking of the fisherman who

21 does not file an income tax return, and because he has a

22 low and a small farm, his real worth is not indicated by

23 the fact that he does not pay income tax.

24 COMMISSIONER FISHBURN: It would be possible

25 for you, in your own mind, to say what the process: "Those

26 who are not real worth, or how these persons can be put

27 into practical legislation, that we might hear from you

28 in your own mind, how this can be put into prac-

29 tice. After all, we, as a Royal Commission, would like





1 your view. We have to come forward with complete proposals.  
2 If you are thinking in terms of a means test, I hope you  
3 can tell the Commission in your supplementary brief how  
4 you can reconcile a means test with the principle that the  
5 opportunity of good health is the right of all. I read it  
6 to you at the beginning and you say you accept it. If you  
7 accept that principle, how do you reconcile that right to  
8 opportunity for good health with a means test? It may be  
9 difficult for you to answer the question. I would be  
10 quite happy if that be defined in the supplementary state-  
11 ment.



1 You are standing in front of a means test, I hope you  
2 can tell the Commission in your supplementary brief how  
3 you can reconcile a means test with the principle that the  
4 opportunity for good health is a right. I think  
5 to you at the beginning and you say you accept it. If you  
6 accept that principle, how do you reconcile that right to  
7 opportunity for good health with a means test? It may be  
8 difficult for you to answer the question. I would be  
9 quite happy if that be defined in the supplementary state-





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1 If I may just make one comment: we do not  
2 think that such individuals would be denied the availabi-  
3 lity of health services. They are not in this province  
4 even though their costs are not met, and we do think  
5 there are other factors such as good roads, and so on,  
6 that makes services available to them although a physician  
7 could not be supported in the exact area where the parti-  
8 cular patient may live. So, there are other factors opera-  
9 ting, and we feel there is no need for people to be denied.

10 DR. JONES: Mr. Chairman, I just wanted to  
11 say it seemed to me there is a fallacy in equating oppor-  
12 tunities of good health with physicians' services. Physi-  
13 cians' services are part of the opportunities for good  
14 health. There are many, many other things that are impor-  
15 tant in the opportunities for good health. I think I  
16 might make a case ~~that~~ improving the diet of pregnant women  
17 is more important than increasing physicians' services,  
18 and I think our point is that if everything is going to be  
19 covered for physicians' services that many other important  
20 opportunities for good health must go by the board.

21 COMMISSIONER FIRESTONE: The point is very  
22 well taken, and we hope we will question others as to the  
23 contributions they can make, but since we are talking to  
24 the doctors we would like to have the views of what the  
25 doctors themselves feel they can contribute.

26 DR. ROSS: This one thousand mentioned here:  
27 that was a figure given us as to people who had received  
28 municipal help during the year, and as far as the means  
29 test is concerned, the diabetics with an income under  
30 \$3,600 a year get free diabetic medicines.

1 If I may just make one comment: we do not  
2 think that such individuals would be denied the equivalent  
3 of health services. They are not in this province  
4 even though their costs are not met, and we do think  
5 there are other factors such as good roads, and so on,  
6 that make services available to them although a physician  
7 might not be available in some cases.  
8 Other patients may live. No, there are other factors open  
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10 Mr. JONES: Mr. Chairman, I just wanted to  
11 say it seemed to me there is a fallacy in equating oppor-  
12 tunities of good health with physicians' services. Physi-  
13 cians' services are part of the opportunities for good  
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15 tant in the opportunities for good health. I think I  
16 might make a case that improving the diet of pregnant women  
17 is more important than increasing physicians' services,  
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19 covered for physicians' services that many other important  
20 opportunities for good health must go by the board.  
21 COMMISSIONER FERGUSON: The point is very  
22 well taken, and we hope we will question others as to the  
23 contribution they can make, but since we are talking to  
24 the doctors we would like to have the views of what the  
25 doctors themselves feel they can contribute.  
26 Mr. ROSS: This one thousand mentioned here  
27 that was a figure given as to people who had received  
28 medical help during the year, and as far as the means  
29 was concerned, the diabetes with an income under  
30 \$2,000 a year get free diabetic medicines.





1 DR. BECKWITH: Mr. Chairman, perhaps it  
2 would clarify our point of view by referring to page 91,  
3 paragraphs 293 and 297 which summarize our thoughts,  
4 first of all from the standpoint of the factual number  
5 involved -- I don't like to use the term "indigent"; we  
6 are trying to get rid of it in these years -- and those  
7 with low incomes are specifically mentioned in paragraph  
8 294 where the total is given as 141,043, and these in  
9 paragraph 295, we say, are easily identifiable citizens  
10 with low incomes and there is probably an economic stratum  
11 where some financial assistance to purchase medical  
12 services will be required.

13 We further recognize that many persons by  
14 reason of the pre-existing disability of age, may require  
15 financial assistance to provide comprehensive coverage  
16 which they need.

17 The first group is

18  
19  
20  
21 COMMISSIONER FIRESTONE: Thank you. If I  
22 may turn now to paragraph 83 at page 720 you speak of "We  
23 know of no commercial carrier that provides a comprehen-  
24 sive level of medical service insurance. On the whole  
25 their plans are marked by indemnity

DR. BECKWITH: Mr. Chairman, perhaps it

clarify our point of view by referring to page 91,

on 293 and 294 which summarize our thoughts.

First of all from the standpoint of the Federal member

involved -- I don't like to use the term "indigent"; we

are trying to get rid of it in these years -- and those

with low incomes are specifically mentioned in paragraph

294 where the total is given as \$41,043, and these in

paragraph 295, we say, are easily identifiable citizens

with low incomes and there is probably an economic situation

where some financial assistance to purchase medical

services will be required.

We further recognize that many persons by

reason of the pre-existing disability of age, may require

financial assistance to provide comprehensive coverage

which they need.

The first group is

may turn now to paragraph 61 on page 750 you speak of "we

know of no commercial carrier that provides a comprehensive

level of medical service insurance. On the whole

these plans are marked by indigence





1 May I address this question to Dr. Giffin:

2 I take it from paragraph 83 that you are referring to  
3 commercial carriers including life insurance companies,  
4 casualty companies etc.?

5 DR. GIFFIN: That is correct, sir.

6 COMMISSIONER FIRESTONE: You are not refer-  
7 ring in this paragraph to co-operative schemes?

8 DR. GIFFIN: I know of no co-operative  
9 scheme. Perhaps Mr. Brannan may know of one.

10 COMMISSIONER FIRESTONE: Let us say a scheme  
11 like your own -- the Maritime Medical Plan: would that be  
12 included under this paragraph 83?

13 DR. GIFFIN: No.

14 COMMISSIONER FIRESTONE: In other words,  
15 this covers life insurance and casualty companies?

16 DR. GIFFIN: That is right.

17 COMMISSIONER FIRESTONE: And you are not  
18 referring to your own plan?

19 DR. GIFFIN: No, we are not referring to our  
20 own plan.

21 COMMISSIONER FIRESTONE: To take it from  
22 here, are you familiar with the practice of some of these  
23 insurance or commercial carriers, as you call them, and  
24 the fact that some may be returning to the insured 90¢ of  
25 the dollar and others may be returning 45¢ of the dollar?  
26 There is a wide range: are you familiar with this?

27 DR. GIFFIN: Speaking personally, there was  
28 a report on it in the Financial Post that recorded the  
29 different levels of return. I have not that table with  
30 me.

Now I address this question to Mr. Griffin:

Take it from paragraph 83 that you are referring to

carefully compared with?

MR. GRIFFIN: That is correct, sir.

COMMISSIONER FINESTONE: You are not refer-

COMMISSIONER FINESTONE: Let me say a sentence

about your own -- the Maritime Medical Plan: would that be

included under this paragraph 83?

MR. GRIFFIN: No.

COMMISSIONER FINESTONE: In other words,

this covers the financial and carefully compared?

COMMISSIONER FINESTONE: And you are not

referring to your own plan?

MR. GRIFFIN: No, we are not referring to our

own plan.

COMMISSIONER FINESTONE: To take it from

now, are you familiar with the practice of some of these

insurance or reinsurance companies, as you call them, and

the fact that some may be returning 95% of

the dollar and others may be returning 85% of the dollar?

There is a wide range; are you familiar with that?

MR. GRIFFIN: Speaking personally, there was

a report on it in the Montreal Post which recorded the

insurance have a lot of return. I have not read that with





1 COMMISSIONER FIRESTONE: Perhaps somebody  
2 among your colleagues can elaborate on this.

3 DR. GIFFIN: Yes. It may be in our papers  
4 because we went over it and discussed that, and did not  
5 include it. One thing, we were a little doubtful about  
6 whether we could substantiate the validity of it.

7 DR. BECKWITH: I was going to say the same  
8 thing. We can put our fingers on the figures, but we do  
9 not have them here, and they are not readily available.

10 COMMISSIONER FIRESTONE: Let us assume the  
11 surveys which the Royal Commission will be carrying out  
12 will confirm the figures -- and we are in a very early  
13 stage and an exploratory stage -- but let us assume it is  
14 confirmed: we don't know if it is true, but we are here  
15 to find out. Let us assume for the moment this is the  
16 case. You have in your proposals a blanket endorsement  
17 of voluntary medical plans: does that equally cover the  
18 company that returns 45¢ out of a dollar as well as the  
19 company that returns 90¢ out of a dollar?

20 DR. GIFFIN: Mr. Chairman, it does not,  
21 because in other places we qualify it as being non-profit,  
22 and it should be comprehensive. In other words, medical  
23 services is a better word than comprehensive, and medical  
24 services as opposed to indemnity plan. So, any plan that  
25 would have a non-profit scheme that would have a medical  
26 service coverage similar to the non-profit medical ones,  
27 the Medical Society has no objection to them being chosen  
28 as an additional or ultimate carrier.

29 COMMISSIONER FIRESTONE: In other words,  
30 when you speak of a comprehensive coverage through



COMMISSIONER FLETCHER: Perhaps somebody

among your colleagues can elaborate on this.

MR. GIBLIN: Yes. It may be in our papers

that we have some information about this.

include it. One thing, we were a little doubtful about

whether we could substantiate the validity of it.

MR. BECKWITH: I was going to say the same

thing. We can put our fingers on the figures, but we do

not have them here, and they are not readily available.

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case. You have in your proposals a blanket endorsement

of voluntary medical plans: does that equally cover the

plans that are of a dollar or a dollar and a half in the

range?

MR. GIBLIN: Mr. Chairman, it does not.

because in other places we qualify it as being non-profit,

and it should be comprehensive. In other words, medical

services is a better word than comprehensive, and medical

services as opposed to indemnity plan. So, any plan that

would have a non-profit scheme that would have a medical

plan would be covered.

COMMISSIONER FLETCHER: In other words,

when you speak of a comprehensive coverage plan



1 voluntary plans, you are referring to non-profit plans,  
2 or are you referring to all commercial carriers?

3 DR. GIFFIN: We are referring essentially  
4 to non-profit plans.

5 COMMISSIONER FIRESTONE: So, the Medical  
6 Society of Nova Scotia holds no brief for commercial  
7 carriers that may be returning only 45¢ out of the dollar  
8 to the insured?

9 DR. BECKWITH: Not so far as service to the  
10 patient is concerned, sir.

11 COMMISSIONER FIRESTONE: Fine; we now under-  
12 stand what you mean. Thank you very much; that is very  
13 helpful.

14 We were discussing yesterday in this connec-  
15 tion, and Mr. Hall, our counsel, asked the question, as to  
16 how you felt about public control. If it is true, as you  
17 say in paragraph 83, that there are commercial carriers  
18 which vary with the type of coverage they provide, the  
19 variations in exclusions and variations in non-coverage  
20 and variations in termination of contract, would you be  
21 in favour, as I understood from what you said yesterday  
22 that you would be, of public control of such insurance  
23 carriers? Did I understand you correctly in answer to a  
24 question by Mr. Hall that you would be in favour of public  
25 control of insurance carriers?

26 DR. GIFFIN: I think our official position  
27 is that we would not be in favour of public control.

28 COMMISSIONER FIRESTONE: You would not be in  
29 favour of public control of what -- of insurance carriers?

30 DR. GIFFIN: Of insurance carriers.

1 voluntary plans, you are referring to non-profit plans,

2 or are you referring to all commercial carriers?

3 to non-profit plans.

4 Society of Nova Scotia holds no policy for commercial

5 carriers that may be returning only 45¢ out of the 50¢

6 to the insured?

7 DR. BROCKWELL: Not so far as service to the

8 patient is concerned, sir.

9 stand what you mean. Thank you very much; that is very

10 We were discussing yesterday in this connec-

11 tion, and Mr. Hall, our counsel, asked the question, as to

12 how you felt about public control. If it is true, as you

13 say in paragraph 83, that there are commercial carriers

14 which vary with the type of coverage they provide, the

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20 question by Mr. Hall that you would be in favour of public

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23 is that we would not be in favour of public control.

24 COMMISSIONER FERGUSON: You would not be in

25 favour of public control of what -- of insurance carriers?

26 DR. GILPIN: Of insurance carriers.





1 COMMISSIONER FIRESTONE: You feel, then,  
2 that it is quite appropriate that the public without  
3 knowing what they are getting in an insurance policy  
4 should be allowed to obtain coverage which will only  
5 return 45¢ out of the dollar and in other cases 90¢ out  
6 of the dollar without the public knowing which is which,  
7 and therefore there is no need, in your opinion, to control  
8 this? There is no need for protection of the public when  
9 there are such great variations?

10 DR. GIFFIN: This gets us in the field of  
11 control. I think it is more a matter from our point of  
12 view of education: how far can you control all aspects of  
13 life without having complete subordination of the indivi-  
14 dual? We would think it would rather be a matter of educa-  
15 tion than direct control.

16 COMMISSIONER FIRESTONE: Are you familiar  
17 that the Superintendent of Insurance carries control of  
18 the operation of insurance companies? It does not go as  
19 far as that at the moment, but it does -- insurance compa-  
20 nies and loan and casualty companies are under Government  
21 control: do you feel this is an imposition on the citizen  
22 because they are in control of a Superintendent of Insu-  
23 rance?

24 DR. GIFFIN: No, that is reading too much  
25 into it. We do know there must be control; there must be  
26 control against fraud, for instance.

27 DR. BECKWITH: Mr. Chairman, I would like to  
28 clarify the point as I understand it -- the point we are  
29 talking about. Medicine, I think, is regarded by the  
30 public as expert and medical education, medical research,

1 COMMISSIONER FRANKLIN: You feel, the  
2 that it is quite appropriate that the public without  
3 knowing what they are getting in an insurance policy  
4 should be allowed to obtain coverage which will only  
5 return 15¢ out of the dollar and in other cases 90¢ out  
6 of the dollar without the public knowing which is which,  
7 and therefore there is no need, in your opinion, to control  
8 this? There is no need for protection of the public when  
9 there are such great variations?

10 DR. GILBERT: This gets us in the field of  
11 control. I think it is more a matter from our point of  
12 view of education; how far can you control all aspects of  
13 life without having complete subordination of the individ-  
14 ual? We would think it would rather be a matter of educa-

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24 DR. GILBERT: No, that is leading too much  
25 into it. We do know there must be control; there must be  
26 control against fraud, for instance.

27 MR. FRANKLIN: Mr. Chairman, I would like to  
28 clarify the point as I understand it -- the point we are  
29 talking about. Medicine, I think, is regarded by the  
30 public as expert and medical education, medical research,





1 to provide quality medical care. When we are supporting  
2 our prepaid voluntary medically sponsored plans as a  
3 method of providing medical services insurance we are pro-  
4 viding it on this basis, that medicine has these fundamen-  
5 tals and we can apply them. We do not state that in the  
6 application of these services to the patient that it is  
7 medicine's prerogative only to do it. We say and admit,  
8 and we are changing all the time insofar as having greater  
9 lay representation on boards, and I have little doubt if  
10 Government were interested in providing medical services  
11 insurance in Nova Scotia on the basis we are talking about  
12 that there would be at least one additional chair put on  
13 the Board of Directors. When we get to the field of  
14 commercial, our approach is an answer to commercial  
15 carriers insofar as we believe comprehensive medical ser-  
16 vices are the basis -- not an exclusion here and an exclu-  
17 sion there and, "If you are sick for so long", or "If you  
18 have this disease you can't have commercial insurance".  
19 That is out. From my point of view the adequacy of medical  
20 service insurance with voluntary prepaid medical plans is  
21 the answer to the deficiencies that exist in commercial  
22 carriers such as you are speaking about with the variation  
23 in return to the patient.

24 COMMISSIONER FIRESTONE: I take it from what  
25 you are saying, gentlemen, this is a question that is rather  
26 important to the medical profession, and that perhaps we  
27 can have some further comments, if you so wish, in any  
28 supplementary submission you may want to make. Can we  
29 leave it at that?

30 DR. GIFFIN: Yes, we will do that.





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our prepaid voluntary medically sponsored plans as a

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viding it on this basis, that medicine has these "undermen-

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vices are the basis -- not an exclamation here and an excla-

tion there and, "If you are sick for so long", or "If you

have this disease you can't have commercial insurance".

That is our view. From my point of view the advantage of medical

service insurance with voluntary prepaid medical plans is

the answer to the difficulties that exist in commercial

carriers such as you are speaking about with the variation

in return to the patient.

COMMISSIONER FINSTON: I take it from what

you are saying, gentlemen, this is a question that is rather

important to the medical profession, and that perhaps we

can have some further comments, if you so wish, in any

amplification you may want to make. Can we

leave it at that?



1 COMMISSIONER FIRESTONE: May I turn now to  
2 paragraph 110 on page 27. You are speaking here of the  
3 Federal plan and you say that you have some doubts about  
4 the advantages of that plan because of the deductible  
5 feature. Can I take it from this paragraph that you are  
6 not in favour of a deductible feature in any scheme that  
7 the Medical Society of Nova Scotia would recommend?

8 DR. GIFFIN: That is our firm view, Mr.  
9 Chairman.

10 COMMISSIONER FIRESTONE: It is quite under-  
11 standable. Can you, then, answer the question of how you  
12 feel that doctors can deal with misuse?

13 DR. GIFFIN: By "misuse" I suppose this  
14 means over-utilization?

15 COMMISSIONER FIRESTONE: Over-utilization,  
16 yes.

17 DR. GIFFIN: And over-servicing by the physi-  
18 cian?

19 COMMISSIONER FIRESTONE: Correct.

20 DR. GIFFIN: Our own Board has a taxing  
21 committee. All doubtful accounts are reviewed by this  
22 committee. If it goes further, it comes to the executive  
23 and if we find any evidence of such a thing the account is  
24 disallowed. There is on our report form a rendered fee  
25 and an allowed fee, and the pro-ratio is based upon the  
26 allowed fee, so that our plan has the machinery for doing  
27 this. When it comes to the over-utilization by a subscri-  
28 ber, our Board has been very lenient. I can't think, as  
29 Mr. Brannan said yesterday, of any example of a contract  
30 being cancelled. Recently several have been written to



COMMISSIONER FIRESTONE: May I turn now to

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our Board has been very lenient. I don't think, as

Mr. Brennan said yesterday, of any example of a contract

being cancelled. Recently several have been written to





1 that have been very, very glaring, and perhaps Mr. Brannan  
2 could give us just the range of some of the figures of  
3 the premium paid in and the amount paid out in service.

4 MR. BRANNAN: I have no figures available  
5 on that at the moment, although the prime concern that we  
6 have in issuing letters to a few of our subscribers  
7 recently was in the field of home and office care where  
8 it appeared as though there was an undue demand for routine  
9 care or perhaps unnecessary care being received. We could  
10 elaborate to some extent on this in a supplementary report  
11 to you, if you wish.

12 COMMISSIONER FIRESTONE: Fine, thank you.  
13 May I turn now to the last group of questioning and deal  
14 with principles. May I address them to Dr. Ross. I  
15 understand, Dr. Ross, that the Medical Society of Nova  
16 Scotia subscribes to the principles which the Canadian  
17 Medical Association has adopted in June 1960 and the text  
18 of which has been tabled with the Royal Commission in its  
19 preliminary hearing on September 27th 1961. Is my under-  
20 standing correct, sir?

21 DR. ROSS: Yes.

22 COMMISSIONER FIRESTONE: May I, therefore,  
23 question you on these principles as being acceptable to  
24 you?

25 DR. ROSS: Yes, sir.

1 had have been very, very stirring, and perhaps Mr. Brennan

2 would give us just the range of some of the figures of

3 the premium paid in and the amount paid out in service.

4 MR. BRENNAN: I have no figures available

5 at that at the moment, although the figures concern that we

6 have in issuing letters to a few of our subscribers

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18 preliminary hearing on September 27 in 1961. Is my under-

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20 COMMISSIONER FIRSTONE: Yes, I, therefore,

21 question you on these principles as being acceptable to

22 you?

23 DR. ROSS: Yes, sir.



L/dpw 1 COMMISSIONER FIRESTONE: Turning to principle  
2 number two, the principle reads that every resident of  
3 Canada is free to select his doctor, that each doctor is  
4 free to choose his patient. Would you explain to me what  
5 this paragraph means, please.

6 DR. ROSS: That is a complementary considera-  
7 tion in our practice. The patient comes to us with one  
8 doctor that he has selected and trusts, he is not sent by  
9 anybody else. No third party intervenes, and he is trusted,  
10 and accepts that trust, and the doctor takes over the care  
11 of that patient, in a personal way. The converse is true,  
12 that any patient that he does not feel he can treat cons-  
13 cientiously he can refuse to do so.

14 COMMISSIONER FIRESTONE: On the first part  
15 of your answer, sir, would you say that if patients are  
16 given the opportunity to choose their doctor and then  
17 registers with the doctor and makes certain payments  
18 worked out with the doctor, that this restraint of the  
19 patient with the doctor would interfere with the freedom  
20 to select their doctor?

21 DR. ROSS: Under our comprehensive plan that  
22 is a very important point. Quite a few of our people  
23 change doctors frequently if they are not satisfied, and  
24 there is no - when the patient comes to us he doesn't  
25 talk about money, he talks about his problem, sickness;  
26 money is the last consideration. Sometimes I think we  
27 are reducing this a little too much to the monetary or  
28 the commercial side. But I really think that there is a  
29 personal bond here that you can't measure in dollars and  
30 cents.





number two, the principle reads that every resident of  
Canada is free to select his doctor, that each doctor is  
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this paragraph means, please.

DR. ROSS: That is a completely consider-  
ation in our practice. The patient comes to us with one  
anybody else. No third party interference, and he is trusted  
and accepts that trust, and the doctor takes over the care  
of that patient, at a certain point, and he is free  
to do what he wants to do and how he wants to do it.

COMMISSIONER WILSON: On the first part  
of your answer, sir, would you say that if patients are  
given the opportunity to choose their doctor and then  
register with the doctor and make certain payments  
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are reducing this a little too much to the monetary or  
the commercial side. But I really think that there is a  
personal bond here that you can't measure in dollars and



1 COMMISSIONER FIRESTONE: You are quite  
2 right, sir; this is the purpose of the question, to bring  
3 out the non-economic, financial side. There is more to  
4 it. Please go ahead, sir.

5 DR. ROSS: Perhaps Dr. Kelly - is he here?

6 COMMISSIONER FIRESTONE: May I just say one  
7 thing, Doctor Kelly. We are really referring here just to  
8 the Nova Scotia Medical Association. While we would like  
9 to hear Doctor Kelly's views - we will on many occasions -  
10 we would like to hear if the views are somewhat in line  
11 with the views that have been given by the National  
12 Association. What we would like to hear is what the  
13 medical profession of Nova Scotia thinks about it.

14 DR. KELLY: I would like to give my Nova  
15 Scotia colleagues the opportunity to say that they have  
16 not been brainwashed by me or the Canadian Medical Associa-  
17 tion.

18 DR. GIFFIN: Mr. Chairman, I can assure you  
19 that we are autonomous and our Chairman has acted on the  
20 General Council for many years, and we have representation,  
21 and we do help to formulate the C.M.A. policy rather than  
22 the other way. We have spelled this out on page 14, para-  
23 graph 31, and this spells out what we consider to be the  
24 very intimate personal relationship between patient and  
25 doctor, that it is a fact in law and that the legal  
26 relationship is, in fact, an implied contract between  
27 patient and doctor. As Dr. Ross has said, the freedom  
28 of the patient to choose his doctor and the freedom of the  
29 doctor to choose his patient, except in an emergency, is  
30 an established usage which time has proven to be eminently

1  
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3 out the non-economic, financial side. There is more to  
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8 the Nova Scotia Medical Association. While we would like  
9 to hear Doctor Kelly's views - we will on many occasions -  
10 we would like to hear if the views are somewhat in line  
11 with the views of the Nova Scotia Medical Association.  
12 I think we would like to hear if the views are somewhat  
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26 relationship is, in fact, an implied contract between  
27 patient and doctor. As Dr. Ross has said, the freedom  
28 of the patient to choose his doctor is a freedom that is  
29 not to be taken away from him. It is a freedom that is  
30 not to be taken away from him.





1 acceptable, and it is, of course, a historic method of  
2 relationship in Canada.

3 In answer to Professor Firestone's question,  
4 if there was a system, no matter what it was, dealing  
5 specifically with the relationship, and the patient in  
6 that system had the right to choose his doctor, why, of  
7 course, it doesn't violate his principle.

8 COMMISSIONER FIRESTONE: I would like to  
9 read to you part of the sentence of the oath that a  
10 doctor takes. It says: "I will use treatment to help the  
11 sick according to my ability and judgment". How do you  
12 reconcile this part of the oath with the case of a doctor  
13 with the right to refuse to see patients?

14 DR. ROSS: Well, it is a matter of conscience  
15 and judgment. Of course, no doctor would ever refuse to  
16 see a patient in an emergency, if he felt he was competent  
17 to handle it. And in another case, of course, if we do  
18 not feel we are competent we refer them to specialists in  
19 that particular field.

20 COMMISSIONER FIRESTONE: In other words,  
21 the phrase "free to choose his patients" means when the  
22 doctor feels he is not competent to deal with it he can  
23 refer to somebody else; it doesn't mean when somebody  
24 comes to him and he doesn't like that particular patient  
25 he says: "I am sorry, I can't see you". I am just  
26 wondering what this phrase means.

27 DR. ROSS: Well, under a free enterprise  
28 system I believe that is an inherent right, providing  
29 other service is available. We don't insist on that too  
30 much; it is something that doesn't come up too often. We

2 relationship in Canada.

3 In answer to Professor Firststone's question,

4 if there was a system, no matter what it was, dealing

5 specifically with the relationship, and the patient in

6 that system had the right to choose his doctor, why, of

7 course, it doesn't violate his principle.

8 COMMISSIONER FIRSTSTONE: I would like to

9 read to you part of the sentence of the oath that a

10 doctor takes. It says: "I will use treatment to help the

11 sick according to my ability and judgment". How do you

12 reconcile this part of the oath with the case of a doctor

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16 see a patient in an emergency, if he felt he was competent

17 to handle it. And in another case, of course, if we do

18 not feel we are competent we refer them to specialists in

20 COMMISSIONER FIRSTSTONE: In other words,

21 the phrase "free to choose his physician" means when the

22 doctor feels he is not competent to deal with it he can

23 refer to somebody else; it doesn't mean when somebody

24 comes to him and he doesn't like that particular patient

25 he says: "I am sorry, I can't see you". I am just

26 wondering what this phrase means.

27 DR. ROSS: Well, under a free enterprise

28 system I believe that is an inherent right, providing

29 other service is available. We don't insist on that too

30 much; it is something that doesn't come up too often, but





1 have to protect our rights a little bit.

2 DR. JONES: Mr. Chairman, I think it is  
3 well recognized that some doctors treat certain patients  
4 badly even although it is within their competence. One of  
5 the problems today is alcoholism, and there are some  
6 doctors cannot tolerate an alcoholic in his office, and  
7 if he comes to that doctor he won't be treated.

8 COMMISSIONER FIRESTONE: May I turn to  
9 principle 13, and I read: "That members of the medical  
10 profession, as the providers of medical services, have  
11 the right to determine the method of their remuneration".  
12 What does this principle mean, sir?

13 DR. GIFFIN: We think that means we have  
14 the right to set our schedule of fees.

15 COMMISSIONER FIRESTONE: I take it you are  
16 talking in this paragraph 13 of the principle of fee based  
17 on a service basis?

18 DR. GIFFIN: Fee for service. We spell that  
19 out under item I, sir.

20 COMMISSIONER FIRESTONE: To go on from there,  
21 what are the objections of doctors to be paid a salary for  
22 services rendered?

23 DR. GIFFIN: Under item I we do recognize  
24 there are certain services which can be best paid by salary,  
25 and, of course, the obvious ones that come to mind are  
26 those concerned in administration, perhaps in public health.  
27 We have suggested that there is another segment that is  
28 going to become increasingly more important, and that is  
29 where a procedure requires a team of approach and a group  
30 of doctors tied up and there is no way of paying them



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COMMISSIONER FLETCHER:

principle is, and I mean: "That members of the medical

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the right to determine the method of their remuneration."

What does this principle mean, sir?

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the right to set our schedule of fees.

COMMISSIONER FLETCHER: I think it is

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DR. GLENN: Yes for service. We spell that

COMMISSIONER FLETCHER: To go on from there,

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those connected in administration, perhaps in public health,

we have suggested that there is another segment that is

going to become increasingly more important, and that is

where a procedure requires a team of approach and a group

of doctors tied up and there is no way of paying them



1 except on that basis.

2 COMMISSIONER FIRESTONE: Let's assume we  
3 have a system of operation where a number of patients are  
4 registered with one doctor and the doctor would be paid on  
5 the basis of the number of patients registered with him.  
6 What would be the objection to such a system?

7 DR. GIFFIN: Our objections to that are on  
8 page 88, paragraph 282, which is essentially a capitation  
9 system, and we see this system as fostering a great uneven-  
10 ness of the workload, and an over-utilization of the  
11 physician's services, resulting in wastage of his energy  
12 and his talents through involvement in minor matters to  
13 the detriment of the quality of his services. It leads to  
14 a lessened time for leisure, study, and this has been put  
15 to you before. These are our objections to the capitation  
16 system.

17 COMMISSIONER FIRESTONE: Have you not  
18 explained a little earlier that your experience in Nova  
19 Scotia has been in the operation of your voluntary plans,  
20 that there hasn't been very much over-utilization? Have  
21 you not explained this a little earlier?

22 DR. GIFFIN: We wouldn't say that propor-  
23 tionately there is a great deal of over-utilization. We  
24 have pointed out in one section of the brief that where  
25 you do have persons covered under an insurance scheme,  
26 then the number of services that the physician performs  
27 are increased, and the figures have gone from 1,200 up to  
28 3,200. Now, there is no question that people are covered  
29 by some form of insurance; the usage is going to increase.  
30 We know it from our own scheme where it involves physicians'



3 have a system of operation where a number of patients are  
4 registered with one doctor and the doctor would be paid on  
5 the basis of the number of patients registered with him.  
6 What would be the objection to such a system?  
7 DR. GIBLIN: Our objection to that one is  
8 page 86, paragraph 288, which is essentially a capitalist  
9 system, and we see this system as fostering a great uneven-  
10 ness of the workload, and an over-utilization of the  
11 physician's services, resulting in waste of his energy  
12 and his talents through involvement in minor matters to  
13 the detriment of the quality of his services. It leads to  
14 a lessened time for lecture, study, and this has been put  
15 to you before. These are our objections to the capitalist

COMMISSIONER FLETCHER: Have you not

20 obtained a little earlier that your experience in how  
21 Scott has been in the operation of your voluntary plan,  
22 that there hasn't been very much over-utilization? Have  
23 you not explained that a little earlier?

DR. GIBLIN: We wouldn't say that proper-

24 tunately there is a great deal of over-utilization. We  
25 have pointed out in our section of the paper that when  
26 you do have persons covered under an insurance scheme,  
27 when the number of services used by the physician increases  
28 and increased, and the figures have gone from 1,500 up to  
29 3,500, now, there is no question that people are covered  
30 by some form of insurance, the usage is going to increase,  
31 we know it from our own scheme where it involves physicians





1 services.

2 COMMISSIONER FIRESTONE: Thank you. May I  
3 now turn to paragraph 14 of the principles, the second  
4 half of that paragraph, which reads: "that all medical  
5 services programs make provision for periodic or automatic  
6 changes in remuneration to reflect changes in economic  
7 conditions". I think that is quite a laudable principle  
8 and quite desirable. I wonder what you mean by "automatic  
9 changes"?

10 DR. GIFFIN: I think the phrase is put in  
11 there rather to stress the fact that if there are economic  
12 changes there shouldn't be a great delay in the adjustment  
13 of our schedule of fees. If it is not periodic and if we  
14 do not have it promptly it is not of much benefit to the  
15 individual practising physician.

16 COMMISSIONER FIRESTONE: In making your  
17 submission to us would it be possible to explain how such  
18 a principle could be put into effect in practice?

19 DR. GIFFIN: We would be very glad to do  
20 that.

21 COMMISSIONER FIRESTONE: I am coming now to  
22 the last question. May I address it to Dr. Ross? It  
23 deals with the main confusion which has been submitted to  
24 us, and if I may read it. "While there are certain  
25 aspects of medical services in which tax-supported programs  
26 are necessary, a tax-supported comprehensive program,  
27 compulsory for all, is neither necessary nor desirable".  
28 Can I question you on some of the words in this paragraph,  
29 Dr. Ross, or would you prefer some of your colleagues to  
30 deal with them? I would like to start off with the first



COMMISSIONER FIRSTTON: Thank you, May 1

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COMMISSIONER FIRSTTON: In making your  
statement to us would it be possible to explain how such  
a principle could be put into effect in practice?

DR. GILPIN: We would be very glad to do

COMMISSIONER FIRSTTON: I am coming now to

the last question. May I address it to Dr. Hays? It  
deals with the main condition which has been mentioned to  
us, and if I may read it: "While there are certain  
aspects of medical services in which tax-supported programs  
are necessary, a tax-supported comprehensive program  
is not necessary for all, is neither necessary nor desirable."  
Now I question you on some of the words in this paragraph.  
Dr. Hays, or would you prefer some of your colleagues to  
deal with them? I would like to start off with the first





1 phrase, "tax-supported". What do you mean by that?

2 DR. GIFFIN: I think the meaning that we  
3 intended to convey there was that it is tax-supported, and  
4 I think the other qualifying word is "compulsory". In  
5 other words, state-financed is the meaning of that.

6 COMMISSIONER FIRESTONE: If I may pursue  
7 this a little further, would you call a program that  
8 consists in part of payment of tax revenue for those  
9 that cannot afford the premium and the payment of others  
10 that can afford it in the form of premiums to a Government  
11 agency, would you call such a system tax-supported?

12 DR. GIFFIN: The answer is no to that  
13 question.

14 COMMISSIONER FIRESTONE: In other words,  
15 may I take it from what you say, sir, that the Medical  
16 Society of Nova Scotia would be in favour of a system,  
17 would support a system where part of the revenue would  
18 come from people paying fees and part from tax revenue  
19 from those who cannot afford it even though that scheme  
20 is run by a Government agency rather than a private orga-  
21 nization?

22 DR. GIFFIN: That would just involve admini-  
23 stration. I don't think for a minute, without consulting  
24 my confreres, that we could have objection to that. But  
25 we would object to having it compulsory, because we think  
26 it would involve such an expenditure of money that other  
27 parts of the program would suffer.

28 COMMISSIONER FIRESTONE: I shall come back  
29 to the word "compulsory" in a minute. I just wanted to  
30 understand your phrase "tax-supported", and may I say we



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intended to convey there was that it is tax-supported, and  
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COMMISSIONER FLESTON: If I may quote

this a little further, would you call a program that  
consists in part of payment of tax revenue for those

that cannot afford the premium and the payment of others

that can afford it in the form of premium as a Government

agency, would you call such a system tax-supported?

DR. GILPIN: The answer is no to that.

COMMISSIONER FLESTON: In other words,

may I take it from what you say, also, that the Medical

Society of Nova Scotia would be in favour of a system

would support a system where part of the revenue would

come from people paying fees and part from tax revenue

from those who cannot afford it even though that scheme

is run by a Government agency rather than a private orga-

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my colleagues, that we could have objection to that. But

we would object to having it compulsory, because we don't

we would involve such an expenditure of money that other

parts of the program would suffer.

COMMISSIONER FLESTON: I shall come back

to the word "compulsory" in a minute. I was wanted to

understand your phrase "tax-supported", and may I say we



1 are interested in obtaining your views, and if you feel  
2 you wish to elaborate in your supplementary submission,  
3 would you please do so. But we are more interested in  
4 your genuine views on this subject.

5 DR. BECKWITH: Mr. Chairman, I imagine we  
6 will be getting a copy of the transcript, and therefore  
7 these questions will be answered.

8 THE CHAIRMAN: A copy of the transcript can  
9 be obtained. There won't be one automatically made  
10 available to anyone in that sense.

11 COMMISSIONER FIRESTONE: May I now come to  
12 the word "comprehensive"? Are you in favour of a compre-  
13 hensive program? As I understood your answer earlier, the  
14 answer was yes.

15 DR. GIFFIN: That is correct.

16 COMMISSIONER FIRESTONE: And that covers  
17 all the Province of Nova Scotia?

18 DR. GIFFIN: It means in our view that it  
19 covers all services that a physician ordinarily renders,  
20 home and office visits, examinations, inoculations, etc.

21 COMMISSIONER FIRESTONE: You are using the  
22 term "comprehensive" in the sense of comprehensive  
23 services?

24 DR. GIFFIN: Yes.

25 COMMISSIONER FIRESTONE: May I ask you  
26 whether "comprehensive" also covers all citizens in Nova  
27 Scotia?

28 DR. GIFFIN: No, we did not look at it in  
29 that way, Mr. Chairman. We were referring by that phrase  
30 only to the services.



1  
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3 would you please do so. But we are more interested in  
4 your genuine views on this subject.

5 DR. BROWTH: Mr. Chairman, I imagine we  
6 will be getting a copy of the transcript, and therefore  
7 these questions will be answered.

8 THE CHAIRMAN: A copy of the transcript can  
9 be obtained. There won't be one automatically made  
10 available to anyone in that sense.

11 COMMISSIONER FIRESTONE: May I now come to  
12 the word "comprehensive"? Are you in favour of a compre-

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15 DR. GILPIN: That is correct.

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17 all the Province of Nova Scotia?

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23 term "comprehensive" in the sense of comprehensive

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29 DR. GILPIN: No, we did not look at it in

30 that way, Mr. Chairman. We were referring by that phrase

31 only to the activities.





1 DR. BECKWITH: I would like to read the  
2 resolution of the 1960 Annual Meeting which provided the  
3 policy of the Medical Society of Nova Scotia. "That the  
4 Medical Society of Nova Scotia at this general meeting  
5 (1960) goes on record and is in accord with a plan for  
6 medical services insurance in Nova Scotia so that the  
7 highest possible quality of medical services will be  
8 available irrespective of income; and furthermore, the  
9 Medical Society of Nova Scotia believes that this can be  
10 brought about by the united efforts and co-operation of  
11 existing agencies interested in and responsible for the  
12 health of the people of Nova Scotia".

13 COMMISSIONER FIRESTONE: Do I understand,  
14 then, that you are planning to make the services available  
15 to all citizens of Nova Scotia?

16 DR. BECKWITH: Sir, in September, 1960, our  
17 committee was familiar with the terms of reference and  
18 that is our view.

19 COMMISSIONER FIRESTONE: Do I take it that  
20 "comprehensive" covers all citizens of the Province of  
21 Nova Scotia or not?

22 DR. BECKWITH: Sir, the term "comprehensive"  
23 from our viewpoint - we are speaking of comprehensive  
24 medical services - is all medical services that are  
25 available.

26 COMMISSIONER FIRESTONE: To all citizens?

27 DR. BECKWITH: Yes, but we don't use it in  
28 that sense. We mean all services. We just chose to make  
29 it all citizens of Nova Scotia shall have comprehensive  
30 medical services.



3 policy of the Medical Society of Nova Scotia. "That the  
4 Medical Society of Nova Scotia at this general meeting  
5 (1960) goes on record and is in accord with a plan for  
6 medical services insurance in Nova Scotia so that the  
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10 brought about by the united efforts and co-operation of  
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14 then, that you are planning to make the services available  
15 to all citizens of Nova Scotia?

16 DR. BROWN: Sir, in September, 1960, one

17 ...

18 ...

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20 "comprehensive" covers all citizens of the Province of

21 Nova Scotia or not?

22 DR. BROWN: Sir, the term "comprehensive"

23 from our viewpoint - we are speaking of comprehensive

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26 COMMISSIONER: To all citizens?

27 DR. BROWN: Yes, but we don't use it in

28 that sense. We mean all services. We just chose to make

29 it all citizens of Nova Scotia shall have comprehensive



1 COMMISSIONER FIRESTONE: I take it from what  
2 you are saying, Dr. Beckwith, that your Society is in  
3 favour of a system or a program which will cover all citi-  
4 zens of Nova Scotia. I think that that answers my question.

5 May I come to the next word in this statement,  
6 and you say "compulsory for all". Are you in favour of a  
7 system that covers everybody in the Province of Nova Scotia?  
8 Those that can afford it, through payment of the premium  
9 by those that can afford it, and those that cannot afford  
10 it through payment from some source of public funds?

11 DR. GIFFIN: The answer is yes, Mr. Chairman.

12 COMMISSIONER FIRESTONE: And "compulsory for  
13 all" would not be applicable to those who cannot afford it  
14 because they will be paid in any event, whether they  
15 choose to be covered or not?

16 DR. GIFFIN: That is our view.

17 COMMISSIONER FIRESTONE: And there "compul-  
18 sory" refers to people who can afford it, and you would  
19 not be in favour of a scheme that would require people to  
20 obtain medical services who can afford it? Is that what  
21 you are saying? Is that what you mean by "compulsory"?

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COMMISSIONER WINSTON: I take it from what

you are saying, Dr. Deschamps, that your Society is in

favour of a system or a program which will cover all

cases of Nova Scotia. I think that that answers my question.

May I come to the next word in this statement.

and you say "compulsory for all". Are you in favour of a

system that covers everybody in the Province of Nova Scotia

those that can afford it, through payment of the premium

by those that can afford it, and those that cannot afford

it through payment from some source of public funds?

DR. DESCHAMPS: The answer is yes, Mr. Chairman.

THE CHAIRMAN: Now, I am going to ask you

all" would not be applicable to those who cannot afford it

because they will be paid in any event, whether they

choose to be covered or not?

DR. DESCHAMPS: Yes, Mr. Chairman.

THE CHAIRMAN: Now, I am going to ask you

any" refers to people who can afford it, and you would

not be in favour of a scheme that would require people to

obtain medical services who can afford it? Is that what

you are saying? Is that what you mean by "compulsory"?



AG/dpw 1 DR. GIFFIN: Our interpretation of the  
2 word "compulsory" is that everyone is forced to become a  
3 subscriber to this scheme, whether he wishes to or not,  
4 and that is to what we are opposed.  
5 COMMISSIONER McCUTCHEON: You would still be  
6 in favour of me paying my own bills if I chose to?  
7 DR. GIFFIN: Yes, but you would be free to  
8 join a scheme but not compelled to.  
9 THE CHAIRMAN: Not a scheme that would  
10 compel a contributor to pay to a specific fund?  
11 DR. GIFFIN: That is better.  
12 COMMISSIONER FIRESTONE: But you do think  
13 this would be contributory to good health service?  
14 DR. GIFFIN: That is right.  
15 THE CHAIRMAN: We have been using the word  
16 "over-utilization", for want of a better word. It has  
17 been pointed up that, say with the insurance schemes, the  
18 co-operative scheme in particular, that where you have a  
19 group covered, that calls upon doctors are substantially  
20 higher than the same number in the group that is not  
21 covered. Have you any views to express on how such  
22 increasing usage might, or should be, controlled?  
23 DR. GIFFIN: Well, in our view, Mr. Chairman,  
24 some of that increasing usage is legitimate..  
25 THE CHAIRMAN: I am not suggesting that it is  
26 not now.  
27 DR. GIFFIN: I wouldn't like to express a  
28 view at the present time, further to what I said earlier  
29 on the method that we use in Maritime Medical Care.  
30 THE CHAIRMAN: Because, you see, the



DR. GIFFIN: Our interpretation of the word "compulsory" is that everyone is forced to become a subscriber to this scheme, whether he wishes to or not, and that is to what we are opposed.

COMMISSIONER MONTGOMERY: You would still be

in favour of me paying my own bills if I chose to?

DR. GIFFIN: Yes, but you would be free to

join a scheme but not compelled to.

THE CHAIRMAN: Not a scheme that would

compel a contributor to pay to a specific fund?

COMMISSIONER MONTGOMERY: But you do think

this would be contributory to good health services?

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THE CHAIRMAN: Because, you see, the





1 question automatically brings us to another expression  
2 that is not liked, and that is used, of the word "deter-  
3 rent fee". Have you an opinion to express on the use of  
4 a deterrent, or I think is a much better expression, a  
5 utilization fee?

6 DR. BECKWITH: This was closely examined  
7 with respect to the hospital insurance plan. The Medical  
8 Society of Nova Scotia chose to advise against the use of  
9 the deterrent. It is an area which is extremely difficult  
10 to utilize, I mean, after all, a mother with a three-months'  
11 old child that wakes up screaming in the middle of the  
12 night may want a doctor right away, and the doctor may go  
13 and find there is a needle in the diaper, or something  
14 like that, but to my mind it is a matter of education,  
15 and that is going to take an awfully long time to achieve.  
16 I do not like to see deterrents, because the very people  
17 that you are trying to assist are the people who are not  
18 going to be able to afford the full insurance. I don't  
19 know what the answer is personally, sir. Certainly we  
20 are giving it a lot of consideration.

21 THE CHAIRMAN: Would you, in the further  
22 submission that you may be making, if you care to express  
23 the view of the Medical Association of Nova Scotia on  
24 this point, and I just mention now in connection with this  
25 that it is quite a live topic. You may have read that the  
26 Thompson Committee in Saskatchewan, in its majority report,  
27 recommended that a utilization fee be applied.

28 DR. GIFFIN: May I just make one comment,  
29 Mr. Chairman? We feel that the deterrent fee may often  
30 deter the patient who may need the service, unless it is



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9 the deterrent. It is an area which is extremely difficult

10 to utilize, I mean, after all, a mother with a three-month

11 old child that wakes up screaming in the middle of the

12 night and has a doctor right away, and the doctor has to

13 get up and go to the house, and the doctor has to be

14 there, and the doctor has to be there, and the doctor has to

15 and that is going to take an awfully long time to achieve.

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17 that you are trying to assist are the people who are not

18 going to be able to afford the full insurance. I don't

19 know what the answer is personally, sir. Certainly we

20 are giving it a lot of consideration.

21 THE CHAIRMAN: Would you, in the further

22 consideration of the subject, would you like to make

23 the case of the hospital insurance in Saskatchewan?

24 Sir, I think that the hospital insurance in Saskatchewan

25 that it is quite a live topic. You may have read that the

26 Thompson Committee in Saskatchewan, in its majority report,

27 recommended that a utilization fee be applied.

28 DR. GLYNN: May I just make one comment,

29 Mr. Chairman? We feel that the deterrent fee may often

30 deter the patient who may need the service, unless it is





1 some major thing, and then they don't think of their  
2 financial commitment, and it really penalizes the doctor.  
3 The fee becomes uncollectable, in other words.

4 DR. BECKWITH: On the other hand, I think  
5 it is essential in human nature, as human nature is, that  
6 participation in these things from the standpoint of  
7 dollars and cents is a very good thing. Certainly the  
8 attempt to get something for nothing is very rampant  
9 these days.

10 THE CHAIRMAN: Then the experience you see  
11 in Australia appears to indicate that in the providing of  
12 drugs, the filling of prescriptions, that there was a  
13 change there in policy from the authority paying for all  
14 the prescriptions to the patient being required to pay the  
15 first shilling or two, or whatever it might be.

16 DR. BECKWITH: I also understand, sir, that  
17 in that connection, that Australia attempted to draw up a  
18 list some 10 years ago of what were termed essential drugs,  
19 and at that time that list numbered some 95. In the  
20 ensuing 10 years this increased to 960 or some such  
21 figure as that. This again is an extremely difficult  
22 area, and as is known in Nova Scotia from the report in  
23 Government that there are certain drugs, and there are  
24 certain other drugs that we would like to see provided to  
25 patients, such as patients receiving treatment for cancer in  
26 the hospital. They have drugs provided free, but when  
27 they leave they have to supply their own drugs, and this  
28 often interferes both from the standpoint of keeping the  
29 patient in hospital longer than is necessary, and also it  
30 inhibits sometimes the treatment that a doctor thinks is





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inhibits sometimes the treatment that a doctor thinks is



1 best for the patient under the conditions, because the  
2 drugs cannot be paid for. The expansion of drug insurance  
3 under those conditions seems to be a reasonable thing,  
4 but that is quite different from the whole matter of all  
5 drugs.

6 THE CHAIRMAN: I am just suggesting now  
7 that the Commission would be interested in having your  
8 views on this co-insurance principle applied to medical  
9 services and any other services that you may care to give  
10 us your views on.

11 DR. ROSS: Under our system in the Maritime  
12 Medical, there is a deterrent fee, because if we have over-  
13 utilization, we have to pro-rate more, and the doctors,  
14 instead of getting 85% as we are getting now, at one time  
15 under a system of old-age pensioners' insurance, who were  
16 very anxious for treatment, it went down to 40%. We got  
17 40% of our fees due to over-utilization. Another thing,  
18 I don't think the deterrent fee actually works, because  
19 under our present system we have fees, and I suppose they  
20 are deterrent, and we have the same people in the office  
21 day after day, and I know under any insurance scheme they  
22 would be there too, but these, at the present time, are  
23 not deterring them.

24 COMMISSIONER BALTZAN: Just one or two  
25 points, gentlemen. In connection with page 97, Appendix I,  
26 I see that you have subscribed, and I read at the bottom  
27 of page 2 that: "Every resident of Canada is free to  
28 select his doctor, and that each doctor is free to choose  
29 his patients". Now, somewhere in the conversation that  
30 we have been listening to at the moment, if I heard it

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COMMISSIONER PATTEN: Just one or two  
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of page 2 that: "Every resident of Canada is free to  
select his doctor, and that each doctor is free to choose  
his patients." Now, somewhere in the conversation that  
we have been listening to at the moment, it is heard in





1 correctly, we are as bad off here as they are further  
2 down, and I want to stand corrected that the reading seems  
3 like this, not here, but as I heard it, that every resi-  
4 dent is free to select his doctor, and each doctor is free,  
5 and this is the word, to refuse his patient. Did I hear  
6 that correctly, and if so the question is, are the two  
7 words, select and refuse, interchangeable? I contend  
8 here that I understand very well ---

9 THE CHAIRMAN: Did you want an answer, Dr.  
10 Baltzan?

11 COMMISSIONER BALTZAN: Well, I would like  
12 to know this, because it was read from here, and somewhere  
13 I heard, and want to hear the answer, did I hear it right?

14 THE CHAIRMAN: Yes, but we didn't give the  
15 panel an opportunity to answer.

16 COMMISSIONER BALTZAN: Yes, Mr. Chairman,  
17 but did I hear it right? I will not ask if it is inter-  
18 changeable, because I will use my own judgment, and I  
19 think everyone has their own judgment. There are diffe-  
20 rent meanings. I heard the word refuse the patient, and  
21 I didn't see it here. I see you have the right to choose,  
22 but not the right to refuse, or at least, the privilege to  
23 refuse. If we are going on this basis here, which I  
24 accept as a submission from the Nova Scotia Medical Society,  
25 that is fine, and if it has another meaning and that word  
26 is interchangeable, perhaps there is an argument on that  
27 point, and if so, I would like to hear it.

28 DR. GIFFIN: In the relationship, doctor to  
29 patient, the right to refuse is inherent. For instance,  
30 we refuse to do an abortion, and for us to do it not too



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patient, the right to refuse is inherent. For instance,

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1 often, but frequently enough to know that you have to  
2 refuse services to a patient, but the way this is phrased,  
3 the selecting and choosing is the correct phrase as it is  
4 here, and you choose the patient, not on the basis if you  
5 don't like him, but perhaps you refuse to treat him on the  
6 basis that you are not the individual to do it. As Dr.  
7 Jones has pointed out, that there is emotional content to  
8 it, and some of us cannot bear an alcoholic, and we cannot  
9 treat an alcoholic. That is the meaning of it, but  
10 certainly when it comes to service there is the right to  
11 refuse.

12 DR. JONES: The major part of my time is  
13 taken up in University instruction. I have a greater  
14 number of patients asking me to treat them than I have the  
15 time to treat. I have not the time, and I tell them it is  
16 not fair to you.

17 COMMISSIONER BALTZAN: Is it fair to say  
18 then, sir, that you choose actually for the benefit of the  
19 patient?

20 DR. GIFFIN: That is the meaning that we  
21 wish to convey there, Mr. Chairman.

22 COMMISSIONER BALTZAN: Thank you, that is  
23 the explanation that I wanted. May I put this, not in the  
24 form of a question, but as one reads improved health  
25 services, the emphasis is on services, the rendering of  
26 attention, improved health services is a double-barrelled  
27 sort of appellation. There is a dual meaning. It applies,  
28 say, for instance, number one, to the quality of doctors,  
29 the quality of training, and then it also applies to the  
30 availability of services, more doctors, ready accessibility





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 refuse services to a patient, but the way this is phrased,  
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COMMISSIONER BALTMAN: Is it fair to say

MR. GIFFIN: That is the meaning that we

wish to convey there, Mr. Chairman.

COMMISSIONER BALTMAN: Thank you, that is

services, the emphasis is on services, the rendering of



1 of services, and more hospital accommodation, better kinds  
2 of service, better kinds of care, but as one reads just  
3 the three words: "improved health services", actually it  
4 means, I take it, that the medical profession does, and I  
5 think everybody else that receives the service, that this  
6 applies to two elements contributing to the one ultimate,  
7 and that is improved service. The one is contingent upon  
8 the other. In other words, you would like this Commission,  
9 it is your intention, without putting words into your  
10 mouths, that direction must be given to the element of  
11 improved quality of training, improved nature of doctors,  
12 and the trends of medicine, as well as making all these  
13 improvements available on the basis of the highest stan-  
14 dards towards the best kind of care that can be taken of  
15 the patient?

16 DR. GIFFIN: That is a superb analysis of  
17 our view, Mr. Chairman.

18 THE CHAIRMAN: Thank you very much, Dr. Ross  
19 and your associates. You need not be in any rush with the  
20 supplementary information that was discussed here this  
21 morning, but we would like to have it as soon as you may  
22 reasonably get your background material to put it together,  
23 and then to send it to our Secretary, Mr. Lafrance, in  
24 Ottawa. Thank you.

25 We will next hear the submission from the  
26 Nova Scotia Dental Association. Dr. Merritt, you will  
27 tender the brief on behalf of the Association?

28 DR. MERRITT: Yes sir.

29 SUBMISSION OF THE NOVA SCOTIA DENTAL ASSOCIATION

30 Appearance: Dr. John E. Merritt



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Dr. GILBERT: That is a superb analysis of

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THE CHAIRMAN: Thank you very much, Dr. Ross  
and your associates. You need not be in any rush with the  
spontaneous information that was discussed here this  
morning, but we would like to have it as soon as you may  
possibly get your background material to put it together,  
and then to send it to our Secretary, Mr. Lawrence, in  
order that we may have it.

We will next hear the resolution from the

Nova Scotia Dental Association. Dr. Merritt, you will

Dr. MERRITT: Yes sir.

SUBMISSION OF THE NOVA SCOTIA DENTAL ASSOCIATION





S U M M A R Y

(CONCLUSIONS AND RECOMMENDATIONS)

1. Nova Scotia dental health is at an extremely low level. We, members of the Nova Scotia Dental Association, believe that this low level of dental health is due to the following factors:

A. Lack of dentists in sufficient numbers to serve the population, and the unequal distribution of these dentists among rural and urban centres.

B. Lack of sufficient preventive measures and public education.

C. Comprehensive dental care, including preventive measures, for every Nova Scotian is the ideal goal, but at present, treatment of dental diseases is beyond the financial resources of a large segment of the population.

D. Failure of the health authorities (municipal, provincial and federal) to recognize dentistry as an integral and equal part of the general health services now being rendered to the public.

2. We believe that the sad situation outlined above can be ameliorated by implementing the following suggestions:

A. Steps should be taken to increase the number of dentists practising in Nova Scotia. Since the cost of studying dentistry is one of the highest in the University, many



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2. We believe that the sad situation outlined above can be ameliorated by implementing the following suggestions:

A. Steps should be taken to increase the number of dentists practicing in Nova Scotia, since the cost of studying dentistry is one of the highest in the University, many



1 academically qualified potential students are  
2 prevented from entering the field because of  
3 lack of funds. It is recommended that the  
4 Federal Government subsidize qualified  
5 dental students directly, for service to the  
6 civilian population.

7 B. Steps should be taken to increase the  
8 number of dental auziliaries employed in  
9 Nova Scotia. The term auxiliaries comprises  
10 the following categories:

11 (i) Dental assistants - receptionists

12 (ii) Dental nurses

13 (iii) Dental hygienists

14 (iv) Dental technicians.

15 C. (i) Steps should be taken to study and  
16 evaluate the incidence and distribution of  
17 dental disease in Nova Scotia via a research  
18 program to be conducted by Public Health  
19 Authorities. This would require the expan-  
20 sion and development of the Dental Division  
21 of the Provincial Public Health Department.

22 (ii) Further professional study by graduate  
23 dentists should be encouraged by tax conces-  
24 sion and deferred write-offs. In this way,  
25 dentistry, as a profession, would enhance its  
26 usefulness and perfect, even further, its  
27 techniques in the service of the public.

28 (iii) Full and effective use should be made  
29 of all mass media in order to educate the  
30 public as to the importance of dental care,





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program to be conducted by Public Health authorities. This would require the expansion and development of the Dental Division of the Provincial Public Health Department. (ii) Further professional study by graduate dentists should be encouraged by the government and deferred where possible. In this way,

dentistry, as a profession, would enhance its usefulness and benefit, even further, its contribution to the service of the public. (iii) Full and effective use should be made of all mass media in order to educate the public as to the importance of dental care,



1 as well as the prevalence, danger, and  
2 disadvantages of dental disease and the  
3 benefits to be derived from preventive  
4 measures and early treatment.

5 D. Since comprehensive dental care is  
6 beyond the purse of a large group of Nova  
7 Scotians, and since professional resources  
8 are limited, public aid should be provided  
9 in an organized and systematic manner.

10 Such aid should first be applied in the  
11 field of child care and in relieving the  
12 most urgent dental needs of all age groups,  
13 as determined by the dental profession.

14 E. Hospitals should be equipped with dental  
15 clinics and personnel to man them. Muni-  
16 cipalities should be assisted in establishing  
17 regional dental clinics which could be  
18 attached to regional schools, thereby making  
19 rural dental care as accessible as education.

20 Priorities should be given to areas where  
21 dental treatment facilities do not presently  
22 exist. The personnel to man these facili-  
23 ties should be engaged by the Provincial  
24 Dental Health Authorities, and the dental  
25 personnel of each Public Health Region  
26 should be under the supervision and direc-  
27 tion of a dentist, who, wherever possible,  
28 should be trained in Public Health. These  
29 facilities should be available to the  
30 dentist to provide services to adults of



as well as the prevalence, danger, and disadvantages of dental disease and the benefits to be derived from preventive measures and early treatment.

D. Since comprehensive dental care is beyond the purse of a large group of Nova Scotians, and since professional resources are limited, public aid should be provided in an organized and systematic manner. Such aid should first be applied in the field of child care and in relieving the most urgent dental needs of all age groups, as determined by the dental profession.

E. Hospitals should be equipped with dental clinics and personnel to man them. Infirmary facilities should be assisted in establishing regional dental clinics which could be

attached to regional schools, thereby making rural dental care as accessible as education.

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exist. The personnel to man these facilities

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1 the region, as time and conditions permit,  
2 on a private patient basis.

3 PREAMBLE

4 3. The Nova Scotia Dental Association in  
5 its annual meeting at Halifax in June of 1961 appointed  
6 a Committee to prepare a brief to the Royal Commission on  
7 Health Services. Its first problem was to find some common  
8 ground amidst the welter of divergent opinion held by the  
9 members of the Association. This section of the Report  
10 will contain many platitudes and attitudes which are  
11 commonly heard when dentists discuss affairs that fall  
12 within the preview of the Royal Commission. Of itself, it  
13 may at times appear confused and conflicting, yet we must  
14 recognize that differences as to the extent to which  
15 problems should be met through group action are not pecu-  
16 liar to Dentistry, but simply reflect the differences of  
17 opinion regarding many social issues.

18 4. The Committee has tried to ascertain  
19 facts which would be useful to the Commission, the  
20 committee members have tried to analyze the problems and  
21 exercise their thoughtful judgment in making specific  
22 recommendations which appear in a later part of this brief.  
23 The problems, which have engaged the constant energies of  
24 the dental profession, have now been placed in the full  
25 glare of public scrutiny.

26 5. If the percentage of citizens getting  
27 the best possible health services is to increase and if  
28 people are to give dental care a higher priority in  
29 family budgets there are a number of difficulties to be  
30 overcome and attitudes to be changed.

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1971/72

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1 6. Salary scales of municipal and provincial  
2 health bodies in Nova Scotia attract only the most dedi-  
3 cated, most desperate or incompetent. The reasons most  
4 dental divisions have not been able to assume the responsi-  
5 bilities they should are clear; most are understaffed and  
6 undersupported and many lack a long range program. One  
7 great contribution this Royal Commission can make to the  
8 goal of the best possible health services would be the  
9 advocacy of such a long range program for the guidance of  
10 the profession, dental educators, and federal, provincial  
11 and municipal legislators.

12 7. It is imperative to point out that  
13 whatever steps are taken, most of the treatment will  
14 continue to be provided by the General Practitioner.  
15 Although the viewpoint of the private practitioner, the  
16 administrator, the public health officer, the dental teacher  
17 and the researcher may vary widely the public need is for a  
18 pooling of the best advice that each of these segments can  
19 provide, and their application to current problems.

20 8. Dental practitioners are in much the  
21 same position as the Newfoundland Firefighters were this  
22 summer -- much too busy to devote sufficient time to lec-  
23 tures on prevention -- yet who can deny the need for the  
24 application of all preventive measures? The backlog of  
25 dental need, the untreated ravages of dental disease and  
26 above all the fear, ignorance and apathy of the general  
27 public all point to the urgent necessity of undertaking  
28 all possible steps to raise the dental, and thus, the  
29 general health of Canadians. Funds commensurate with  
30 objectives must be allocated. All persons whose level of





6. Salary scales of municipal and provincial

health bodies in Nova Scotia affect only the most dedi-

cated, most desperate or incompetent. The reasons most

often given for this are that the health bodies are

not allowed to pay more than the municipal and provincial

rates, and that the health bodies are not allowed to

pay more than the municipal and provincial rates.

It is true that the health bodies are not allowed to

pay more than the municipal and provincial rates, and

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than the municipal and provincial rates.

It is also true that it is impossible to point out that

whatever steps are taken, most of the treatment will

continue to be provided by the General Practitioner.

Although the viewpoint of the private practitioner, the

administrator, the public health officer, the dental teacher

and the researcher may vary widely the public need is for a

system of health care which is efficient and economical

and which is based on the principles of preventive medicine.

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1 income is insufficient to bear the burden of income tax  
2 should be guaranteed a minimum level of dental care. The  
3 cost of rendering this minimal care has been borne by the  
4 dental profession. It is time that it should be shared by  
5 the larger community. Minimal care is not enough, all  
6 persons should be encouraged to provide the balance of  
7 treatment as their resources permit.

8 9. The Dentist enters the profession  
9 knowing that the primary purpose of his education and licen-  
10 sure is to render health service care. To make this care  
11 available to the public he needs an office with adequate  
12 space, costly equipment, trained auxiliary help, proper  
13 insurance and an efficient accounting system. Accelerating  
14 costs of operating a dental office and complicated tax and  
15 legal questions make modern practice a complex responsibi-  
16 lity. The dentist must manage his practice in such a way  
17 that he can offer the patient the best dental service that  
18 he is able to provide; he must provide for his family and  
19 his old age, and as an educated man, dedicated to health  
20 service, he should participate in those programs which  
21 contribute to the health and welfare of his community.  
22 Dentistry therefore challenges the integrity, intelligence,  
23 and skill of those who choose it as a profession. As an  
24 essential health service it should offer to those who  
25 enter the profession the respect and appreciation of  
26 society. Solo practice permits the maximum freedom of  
27 action and expression of individuality. The Dentist's  
28 ability, integrity and judgment determine the quality of  
29 his service. Many dentists believe that solo practice  
30 provides the most effective type of service; the public



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1 attitude emphasizes this.

2 10. If the number of patients increases  
3 markedly then the opportunities for disagreement can  
4 multiply like accidents on an overcrowded highway. Quality  
5 control is a function of the conscience of the person  
6 rendering the service. Slackness should be checked, but  
7 this in turn requires delegation of authority from some  
8 competent body to prevent unqualified persons from  
9 offering to provide service for which they have neither  
10 the skill, the training nor the understanding. The quali-  
11 fied dentist must be free to recommend the treatment which  
12 he feels is in the best interest of the patient, and the  
13 patient must be free to accept this opinion or seek another.  
14 The patient should not be required to submit to treatment  
15 which he does not consider to be in his best interests.  
16 Freedom of choice by both dentist and patient is essential.

17 11. Treatment benefits should be provided  
18 on the basis of professional need, primarily, for if pro-  
19 vided on the basis of social need the public will go to  
20 extreme length to prove this social need. The decision  
21 as to whether the patient needs the care must remain with  
22 the dentist.

23 12. Members of the profession must preserve  
24 a scholarly curiosity and have time for research in both  
25 basic and clinical sciences, time to contribute to the  
26 community and time to meditate. The professional good and  
27 the public good are indivisible. Members of the profession  
28 can be trusted with administrative responsibility insofar  
29 as it concerns dental health services.

30 Although it is but one hundred and twenty



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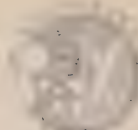




1 years since the first college devoted to the study of  
2 dentistry opened its doors, dentistry in North America  
3 has made phenomenal strides. It is no accident that this  
4 period of progress coincides with the independence of  
5 dentistry. If at first dentistry was predicated on the  
6 development of mechanical skills, in the last epoch  
7 dentistry has been increasingly concerned with the biolo-  
8 gical sciences which have for some time now formed the  
9 basis of practice and teaching. The two professions,  
10 medicine and dentistry, are drawing closer together.  
11 There is much in common between them, and the dental pro-  
12 fession is willing and anxious to co-operate in advancing  
13 the health standards of the public. Co-operation implies  
14 a large measure of self-determination and the organization  
15 of any health scheme should include budgetary liberty in  
16 planning dental programs in the best interests of the  
17 public.

18 14. The American Dental Association plan of  
19 insurance coverage permits professional freedom, encourages  
20 free selection by both the patient and the dentist, and  
21 retains financial participation which is so necessary if  
22 the patient is to appreciate the value of the service  
23 performed. The area for government action is in organiza-  
24 tion, legislation, and assistance to those who are unable  
25 to financially meet the patient's portion of the fee, and  
26 ensuring that children who have not come to the age of  
27 discretion shall not suffer privation and the effect of  
28 prolonged deferment of needed treatment. It would appear  
29 that an insurance plan with a deductible feature is the  
30 only reasonable alternative to a full-scale medical and





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14. The American Dental Association plan of insurance coverage permits professional freedom, encourages free selection by both the patient and the dentist, and retains financial participation which is so necessary if the patient is to appreciate the value of the service performed. The area for government action is in organization, legislation, and assistance to those who are unable to financially meet the patient's portion of the fee, and ensuring that children who have not come to the age of discretion shall not suffer privation and the effect of prolonged deferment of needed treatment. It would appear that an insurance plan with a judicious feature is the only reasonable alternative to a full-time medical staff.



1 dental plan set up on the basis of physicians and dentists  
2 being salaried employees of the state or recipients of  
3 fixed annual payments per listed patient. Both of these  
4 latter are less desirable than the fee-for-service basis  
5 and the good doctor-patient relationship which this engen-  
6 ders and which the public and profession prefer.

7 15. Standardization of methods and materials  
8 is not desirable. Variety can lead to equally good  
9 results and sometimes to improve results. This is the way  
10 to progress. Let us have frankness in weighing the rela-  
11 tive merits of different methods, dramatizing successes  
12 and illuminating failures.

13 16. So long as we approach the problems  
14 with the principles of free inquiry, a candid discussion  
15 of the problems, initiating only those programs which are  
16 dictated by social and cultural pressures; so long as we  
17 fearlessly recommend solutions appropriate to the existing  
18 problems, discarding falsehood and prejudice and enhancing  
19 truth we shall continue to make progress. The evidence of  
20 experience should not be lightly put aside. Even if the  
21 pace of social change is quickening we should adhere to an  
22 enlightened program sparked by imagination and stubborn  
23 leadership.

24 EXISTING FACILITIES AND METHODS

25 EXISTING FACILITIES:

26 17. a. Private offices are reasonably well  
27 equipped but some are not sufficiently large to provide  
28 accommodation for auxiliary personnel. Many dentists  
29 employ one Assistant-Receptionist but many operate without  
30 chairside assistants. Most dentists employ the services



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an assistant assistants. Most dentists employ the services





1 of commercial dental laboratories but many dentists do some  
2 laboratory work and are capable of doing any portion of  
3 such work. There are approximately 151 such dental offices  
4 in this Province.

5 18. b. Teaching Institutions - Well-equip-  
6 ped clinic with 34 dental operators commonly staffed by  
7 students under the direction of five full-time dentists  
8 and 23 part-time practitioners.

9 19. c. Federal Organizations: R.C.D.C.  
10 Approximately 30 Dental Officers employed in well-equipped  
11 clinics staffed with auxiliaries and cleaning staff  
12 together with adequate laboratory facilities and personnel.  
13 This segment of the profession supplies treatment to a  
14 preferred segment of society; the Armed Services, as a  
15 part of the terms of service.

16 20. D.V.A. Three Dental Officers and auxi-  
17 liaries in a well-equipped clinic serving those who qualify  
18 for treatment.

19 21. d. Provincial Organizations: The  
20 Dental division of the Department of Public Health. This  
21 includes two Dental Officers - one an administrator and  
22 the other an operator, together with part-time Dental  
23 Officers (usually for two months of the year) manning the  
24 Public Health clinics.

25 22. e. Municipal Organizations: School  
26 Dental service is extremely limited. Halifax has one  
27 full-time Dentist and two part-time Dentists. Clinic  
28 facilities are provided on a limited basis in some schools.  
29 With 18,000 children this service is almost entirely of an  
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1 23. f. Other Organizations: The Mackay  
2 clinic employing one Dentist and adequately equipped.  
3 The Dentist is engaged under contract to provide part-time  
4 service to the school children and the balance of his  
5 business hours are devoted to others who require dental  
6 treatment on a fee for service basis - Shelburne County  
7 only.

8 EXISTING METHODS:

9 24. a. The person selects the Dentist of  
10 his choice and applies for treatment.

11 25. b. The Dentist makes an appointment  
12 for consultation and examination at this time. If the  
13 case is unusually complicated the Dentist makes a provi-  
14 sional diagnosis and indicates the priority or urgency of  
15 treatment which he feels is required. The Dentist makes  
16 treatment recommendations and possible alternatives when  
17 such exist.

18 26. c. The prospective patient either (i)  
19 concurs or (ii) offers other factors for consideration or  
20 (iii) selects from the alternatives provided or (iv)  
21 requests information regarding other treatment procedures  
22 which the prospective patient believes might be applicable  
23 in his case or (v) rejects the Dentist's recommendations.

24 27. d. The Dentist, after considering the  
25 prospective patient's wishes, will make a firm diagnosis  
26 and, if possible, he may modify his treatment plan to meet  
27 the prospective patient's social needs, psychological needs  
28 and financial situation.

29 28. e. When both Dentist and prospective  
30 patient have a clear understanding of the





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28. e. When both Dentist and prospective

patient have a clear understanding of the



1 nature of the treatment to be undertaken, and the fee  
2 which will apply, the prospective patient is accepted as a  
3 patient and the necessary appointments are made to complete  
4 the required treatment. When the treatment is completed  
5 the patient either pays cash, or agrees to pay by cheque  
6 when billed, or agrees to pay by installments.

7 29. THIS SEQUENCE OF AGREEMENT TREATMENT  
8 AND PAYMENT IS so much a part of the fabric of the prac-  
9 tice of Dentistry that it must be considered a principle  
10 and should not lightly be discarded or abridged.

11 30. f. Treatment is available at Dalhousie  
12 University Clinic but the basis of selection of cases is  
13 the teaching value which each case presents. When accepted,  
14 patients usually receive extensive care at reduced fees.

15 31. g. School service + treatment is  
16 necessarily limited by the number of students and by  
17 professional resources. With 18,000 children in Halifax,  
18 the level of treatment is necessarily very low. It does  
19 and must consist largely of primarily relief of pain,  
20 urgently required filling of permanent teeth and palliative  
21 treatment of carious deciduous teeth.

22 32. h. Provincial Health Service: This  
23 service is much appreciated by the Dental Profession and  
24 the director should be complimented on the fine preventive  
25 work that is being done by this Department with the limited  
26 resources at hand.

27 33. i. Federal Health Dental Care: Those  
28 who qualify for treatment receive much better care than  
29 the national average but some categories of treatment are  
30 available only in very special circumstances. In spite of



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1 the fact that service personnel is qualified for treatment,  
2 it appears that, at times, the exigencies of the service  
3 prevent qualified persons from obtaining treatment when  
4 they would like to have it. Service personnel have been  
5 known to seek the services of civilian practitioners when  
6 either the nature of the work or the pressures on the  
7 service Dentists prevented them from receiving the neces-  
8 sary treatment.

9                   34. J. Method of Determining Fees: The  
10 soundest method of determining fees is one based on the  
11 value of the service to the patient, the time required to  
12 perform the service and the overhead cost of maintaining  
13 a dental establishment. The value of the service in intan-  
14 gible; it concerns the opinion of the patient and the judg-  
15 ment of the dentist. The time and cost factors are tan-  
16 gible and measureable. Dependable estimates show that  
17 dentists work from 1200 to 1800 productive hours per year.  
18 (Productive hours are considered to be those periods during  
19 which the dentist performs a service for which he receives  
20 a fee). The 1958 survey reported that the average dentist  
21 spent 1618 productive hours at the chair. When the number  
22 of productive hours are divided into the total fixed over-  
23 head costs such as rent, utilities, services of auxiliaries,  
24 laundry and insurance, amortization of equipment, the  
25 result is the fixed overhead cost per hour. To this is  
26 added the cost of supplies and any laboratory service.  
27 The dentist must then consider other factors, some of them  
28 intangible; the difficulty of the operation, the experience  
29 and skill required, his investment in education, the cost  
30 of equipping an office, depreciation loss, the cost of



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1 continuing education, the cost of purchasing new equipment,  
2 the cost of introducing more demanding techniques, payment  
3 of premiums on sickness and accident and overhead insurance,  
4 support for an adequate retirement plan, the standard of  
5 living required by his family and finally the patient's  
6 ability to pay.

7 35. Mean salaries paid to assis-  
8 tants . . . . . \$2703.00  
9 receptionists and secre-  
10 taries. . . . . 2931.00  
11 technicians . . . . . 4652.00  
12 Hygienists. . . . . 4396.00  
13 Total - one each. . . . . \$14682.00

14 or \$1223.00 per month for salaries alone.

15 36. The survey of dentistry conducted largely  
16 by persons who were not dentists said, "the median net  
17 income is not high considering the dentist's educational  
18 background and skills and capital investment".

19 37. k. Dentists have maintained that under  
20 insurance programs covering general health case patients  
21 are entitled to certain benefits that dentists are able  
22 and licensed to provide. The PENN Dental Society was the  
23 first to negotiate a revision in Blue Shield plans which  
24 permit direct payment to Dentists for medical and surgical  
25 treatment of acute oral disease. The New York State Dental  
26 Society won the same right through the courts. It main-  
27 tains that the dental licensing laws grant the dentists  
28 the right to perform certain surgical procedures which  
29 contribute to better and more comprehensive health care.  
30 It further maintains that if the benefits are included in





continuing education, the cost of purchasing new equipment  
 the cost of introducing more demanding techniques, payment  
 of premiums on sickness and accident and overhead insurance  
 support for an adequate retirement plan, the standard of  
 living required by his family and finally the patient's  
 ability to pay.

35. Mean salaries paid to assistants

dentists . . . . .	\$8703.00
receptionists and secretaries . . . . .	2581.00
technicians . . . . .	4082.00
Hygienists . . . . .	4150.00
Total - one each . . . . .	\$14522.00

or \$1223.00 per month for salaries alone.

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by persons who were not dentists said, "the median net  
 income is not high considering the dentist's educational  
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 contribute to better and more comprehensive health care.  
 It further maintains that if the benefits are included in



1 a contract the subscriber must receive reimbursement for  
2 the service whether it is performed by a dentist or by a  
3 physician. The New York Supreme Court upheld the position  
4 of the State Dental Society and thereby upheld and streng-  
5 thened Dentistry's position as an integral part of any  
6 health service.

7 38. 1. The Minimum Wage Act in Nova Scotia  
8 provides \$14.00 - \$21.00 per week depending on the area  
9 within the Province; this cannot provide much more than  
10 food and shelter. How can persons on the minimum wage  
11 provide professional health care services?

12 39. m. For many years as the dental popula-  
13 tion of the Province has been shrinking Dentists have been  
14 congregating more and more in the urban centres. The  
15 rural areas have been gradually deprived of convenient  
16 dental service. Centres such as Barrington Passage, Ayles-  
17 ford, Lawrencetown, Berwick, Avonport, Shubenacadie, Middle  
18 Musquodoboit, Arichat, Sheet Harbour, Tatamagouche, Canso,  
19 Guysborough, Sherbrooke, Inverness, Whycogomagh, Baddeck  
20 and, no doubt, others which formerly had Dentists now have  
21 none. Most of the urban Dentists have very close appoint-  
22 ment schedules and only at great inconvenience to themselves  
23 and their regular patients can they deal with emergency  
24 treatment.

25 40. PREVENTIVE MEASURES:

- 26 a. Fluoridation of public water supplies.  
27 b. Adequate home care.  
28 c. Periodic scaling and cleaning by Dentist  
29 or Hygienist.  
30 d. Educating the public to understand the



a contract and subscriber must receive reimbursement for the service whenever it is performed by a dentist or by a physician. The New York Supreme Court upheld the position of the State Dental Society and thereby upheld and strengthened Dentistry's position as an integral part of any health service.

38. 1. The Minimum Wage Act in New York provides \$14.00 - \$21.00 per week depending on the area within the Province; this cannot provide much more than food and shelter. How can persons on the minimum wage provide professional health care services?

39. 1. For many years as the dental population of the Province has been shrinking Dentists have been congregating more and more in the urban centers. The rural areas have been gradually deprived of convenient dental services. Counties such as Raritan, Passaic, Aylesford, Lawrenceville, Newark, Avenor, Shubertsville, Middletown, Atcham, West Harbor, Tottamagouche, Gans, and, no doubt, others which formerly had Dentists now have none. Most of the urban Dentists have very close appointment schedules and only at great inconvenience to themselves and their regular patients can they deal with emergency

a. Fluoridation of public water supplies.

c. Periodic scaling and cleaning by Dental

or Hygienist.

d. Educating the public to understand the





value of good dental care and proper attention to good dietary habits.

e. Topical applications of Caries Inhibitors.

f. Fluoride tablets where no communal water supply exists.

g. Fluoridated tooth paste.

h. Research into the cause and treatment of dental disease.

1. With a quickening interest in rehabilitation of deformities of malocclusion in children many Dentists are undertaking preventive and simple treatment of orthodontic cases.

41. Hospital Service: There are a very few appointments to Hospital staffs; there is some interest in training for hospital appointments; Municipalities which have expressed the desire to include dental facilities in hospitals being constructed have been discouraged from including these facilities in the final plans.

42. Auxiliaries: A good dental assistant is virtually another pair of hands for the Dentist while the patient is in the chair. She reduces the time of operative procedure and thereby reduces the period of apprehension, discomfort and inconvenience that the patient might experience.

43. Before an appliance can be prescribed a diagnosis must be made. The condition of the oral mucosal membrane plays an important part in the diagnosis, design and prognosis of oral appliances. The tissues of the mouth may be subject to varying amounts of stress. The Dental Technician develops speed and proficiency in technical



value of good dental care and proper action-

tion in dental health.

e. Topical applications of Caries Inhibitor

f. Fluoride tablets where no communal water

supply exists.

g. Fluoridated tooth paste.

h. Research into the cause and treatment of

dental disease.

i. Dental health services in communities

tion of deformities of malocclusion in chil-

dren many Dentists are undertaking preventive

and simple treatment of orthodontic cases.

41. Hospital Service: There are a very few

hospitals in which dental service is provided in

the hospital building, but in many cases the

dental service is provided in a separate building

which is usually a part of the hospital complex.

42. Auxiliary: A good dental assistant is

virtually another pair of hands for the dentist while the

patient is in the chair. She reduces the time of operative

procedure and thereby reduces the period of apprehension.

43. Diagnosis: The condition of the oral tissues

and the general health of the patient are

important factors in the diagnosis, design

and prognosis of oral appliances. The thickness of the

muscle and the amount of stress. The Dental

Technician develops speed and proficiency in technical





1 performance but he is not qualified by education or other  
2 formal training to diagnose the need for appliances, to  
3 plan treatment, to design appliances or to analyze their  
4 functioning in the oral cavity. To perform these functions  
5 we need a knowledge of Anatomy, Pathology, Physiology and  
6 their application in practice - knowledge which the Dentist  
7 obtains in his dental undergraduate program.

8 44. There are a number of commercial dental  
9 laboratories in Nova Scotia with well qualified technicians  
10 and some very skilled mechanics in any one of several  
11 specialized lines of prosthetic service. Most are very  
12 loyal and skilled workers to whom many dentists entrust  
13 the fabrication of appliances upon prescription. We must  
14 also confess that we have knowledge of alleged illegal  
15 practice but note that these persons are not subject to  
16 censure by the Provincial Dental Board - they can only be  
17 prosecuted after proof of an illegal act has been obtained.

18 45. DENTIST TO POPULATION RATIO:

19 Nova Scotia 1948 -- 1:: 3369

20 Nova Scotia 1959 -- 1:: 4635

21 Canadian Average 1959 -- 1:: 3018

22 R.C.D.C. 1959 -- 1:: 950

23 These ratios are expected to decline as the average age of  
24 practitioners increases and more men are likely to be lost  
25 in the next few years through death and retirement due to  
26 the heavy physical demands that the practice of dentistry  
27 makes upon the health of the practitioner.

28 46. PROJECTED PROFESSIONAL PERSONNEL: At  
29 the rate of approximately three per year in general prac-  
30 tice the ratio is expected to decline for some years to





plan treatment, to design appliances or to analyze their  
functioning in the oral cavity. To perform these functions  
we need a knowledge of anatomy, pathology, physiology and  
their application in practice - knowledge which the dentist  
must have. 44. There are a number of commercial dental

laboratories in Nova Scotia with well qualified technicians  
and some very skilled mechanics in any one of several  
specialized lines of prosthetic services. Most are very  
loyal and skilled workers to whom many dentists entrust  
the fabrication of appliances upon prescription. We must  
also confess that we have knowledge of alleged illegal  
practice but note that these persons are not subject to  
censure by the Provincial Dental Board - they can only be  
prosecuted after proof of an illegal act has been obtained.

45. DENTAL TO POPULATION RATIO:

Nova Scotia 1948 -- 1: 3360
Canadian Average 1959 -- 1: 3018
R.C.D.C. -- 1: 250

These ratios are expected to decline as the average age of  
practitioners increases and more men are likely to be lost  
in the next few years through death and retirement due to  
the heavy physical demands that the practice of dentistry  
places upon the health of the practitioner.

the rate of approximately three per year in general practice the ratio is expected to decline for some years to



1 come. Even if the graduating high school students could  
2 be encouraged to enter Dentistry in sufficient numbers to  
3 fill the vacancies at Dalhousie it would take about seven  
4 years before the effect of this program would be felt.  
5 And there is a distinct possibility that the armed forces  
6 would require an increased allotment from the graduating  
7 class. At the present time it requires 15% of the profes-  
8 sional personnel available in this Province to supply more  
9 or less complete care to the Department of Veterans'  
10 Affairs. War Veterans' allowance recipients and the Armed  
11 Services form roughly 2.3/4% of the population of Nova  
12 Scotia. A projection of this figure shows that a sevenfold  
13 increase in the number of Dentists would be required to  
14 supply dental service to the same level as now exists.

15 47. (B) METHODS OF IMPROVING EXISTING  
16 DENTAL HEALTH SERVICES: Section 1 - Since recommendations  
17 are requested "to ensure that the best possible health  
18 care is available to all Canadians", and ALL is a defini-  
19 tive term, it is assumed that this Commission in its  
20 inquiry into Dental Health Conditions in Nova Scotia is  
21 mainly concerned with the three-quarters of the population  
22 of Nova Scotia which is entirely lacking in dental treat-  
23 ment. It is assumed that the other one-quarter of the  
24 population is at present receiving the best possible dental  
25 care under existing facilities.

26 48. Recommendations for the improvement of  
27 present dental health services therefore are offered to  
28 improve the quantity of treatment without sacrificing  
29 quality. Before prescribing a cure for the present inade-  
30 quate services it is necessary to re-examine the cause.



come. Even if the graduating high school students could be encouraged to enter dentistry in sufficient numbers to fill the vacancies at Dalhousie it would take about seven years before the effect of this program would be felt. And there is a distinct possibility that the armed forces would require an increased allotment from the graduating class. At the present time it requires 15% of the provincial personnel available in this Province to supply more or less complete care to the Department of Veterans' Affairs. War Veterans' allowance recipients and the Armed Services form roughly 2.3% of the population of Nova Scotia. A projection of this figure shows that a sevenfold increase in the number of dentists would be required to supply dental service to the same level as now exists.

47. (b) METHODS OF IMPROVING EXISTING

DENTAL HEALTH SERVICES: Section 1 - Since recommendations are requested "to ensure that the best possible health care is available to all Canadians", and AHA is a definite term, it is assumed that this Commission in its inquiry into Dental Health Conditions in Nova Scotia is mainly concerned with the three-quarters of the population of Nova Scotia which is entirely lacking in dental treatment. It is assumed that the other one-quarter of the population is at present receiving the best possible dental

48. Recommendations for the improvement of

present dental health services therefore are offered to quality. Before prescribing a care for the general trade-dental services it is necessary to re-examine the entire





1 To look at the matter superficially, the inadequate service  
2 is a result of a shortage of dentists. The underlying  
3 cause, however, is largely economic in character, the  
4 shortage of dentists being a result, largely, of the law  
5 of supply and demand. High education costs and long years  
6 of effort are required to qualify. The future of the  
7 graduate depends on tedious personal effort and aptitude,  
8 all dependent on the maintenance of good health in a  
9 profession which is demanding on nervous and physical well-  
10 being.

11 49. The economic factors, other than perso-  
12 nal ones, are the relative abilities of the individual,  
13 the municipality, or the Province to meet the cost of indi-  
14 vidual treatment. The impact of this increases the closer  
15 it gets to the individual, particularly if of lower income  
16 bracket, with a large family. In Provincial and Municipal  
17 Dental Health projects, feeble and inadequate as they are,  
18 the salaries provided are extremely unattractive. If the  
19 law of supply and demand for dentists is an index of the  
20 economic standard of the Province, the Dentist to popula-  
21 tion ratio would indicate that the ability of Nova Scotia  
22 to support public services is but three-quarters of that  
23 of Canada, as a whole.

24 50. Section 2 - It is suggested that the  
25 constitutional division of Legislative Powers in Canada,  
26 and consequently responsibility for such matters as health  
27 services and higher education, be re-assessed under modern  
28 conditions. It is difficult to believe that the Fathers  
29 of Confederation could foresee a time when one of the  
30 Provinces, one with the least financial resources, would



To look at the matter superficially, the inadequate service is a result of a shortage of dentists. The underlying cause, however, is largely economic in character, the shortage of dentists being a result, largely, of the law of supply and demand. High education costs and long years of effort are required to qualify. The future of the graduate depends on tedious personal effort and application. All dependent on the maintenance of good health in a profession which is demanding on nervous and physical well.

49. The economic factors, other than personal ones, are the relative abilities of the individual. The impact of this increases the closer it gets to the individual, particularly if of lower income bracket, with a large family. In Provincial and Municipal Dental Health projects, feeble and inadequate as they are, the individual's economic position is a major factor. The individual's economic position is a major factor. The individual's economic position is a major factor.

50. Section 2 - It is suggested that the constitutional division of legislative powers in Canada, and consequently responsibility for such matters as health services and higher education, be re-assessed under modern conditions. It is difficult to believe that the Western or Confederation could foresee a time when one of the provinces, one with the least financial resources, would





1 be footing the bill for the education of graduates to  
2 serve other provinces, or the Federal Government. Yet we  
3 have a situation now concerning a short supply of graduates  
4 from Dalhousie to reinforce the depleted ranks of the  
5 Dental Profession in Nova Scotia. To keep them in opera-  
6 tion, the Nova Scotia Government is subsidizing the medical  
7 and dental faculties at the rate of \$2356.50 per student  
8 per year. At the same time 68.5% of the dental students  
9 are now from outside the Province. The Royal Canadian  
10 Dental Corps is subsidizing the education of dental stu-  
11 dents who enter the Corps an approximately equal amount.  
12 In this way, during the last eleven years, 40% of the Nova  
13 Scotian Dental graduates have been educated by the Province  
14 for the use of the Federal Government. During the same  
15 period the Dentist-Patient ratio in Nova Scotia has  
16 decreased from 1:3389 to 1:4635.

17 51. Therefore it is recommended that the  
18 responsibility of the Federal Government be re-examined  
19 in relation to federal support to higher education in pro-  
20 fessional faculties, thus partially relieving the Province  
21 of Nova Scotia of that burden. If the extreme and increa-  
22 sing shortage of dental health services is due to lack of  
23 economic resources, a relief of the burden of educating  
24 graduates for service elsewhere than in the Province  
25 would release provincial revenue to provide better health  
26 services.

27 52. Section 3 - Any major improvement in  
28 dental health services depends primarily on an increase in  
29 the number of dentists in the Province. In 1950 there were  
30 177 Dentists in private practice in Nova Scotia. In 1960





serve other provinces, or the Federal Government. Yet we have a situation now concerning a short supply of graduates from Dalhousie to reinforce the depleted ranks of the Dental Profession in Nova Scotia. To keep them in operation, the Nova Scotia Government is subsidizing the medical and dental facilities at the rate of \$2356.50 per student per year. At the same time 68.7% of the dental students are now from outside the Province. The Royal Canadian Dental Corps is subsidizing the education of dental students who enter the Corps an approximately equal amount. In this way, during the last eleven years, 40% of the Nova Scotian Dental Graduates have been educated by the Province for the use of the Federal Government. During the same

decreased from 1:389 to 1:463.

21. Therefore it is recommended that the

responsibility of the Federal Government be re-examined in relation to Federal support to higher education in Nova Scotia of that burden. If the extreme and increasing shortage of dental health services is due to lack of would release provincial revenue to provide better health services.

22. Section 2 - Any major improvement in

dental health services depends primarily on an increase in the number of dentists in the Province. In 1950 there were 177 dentists in private practice in Nova Scotia. In 1955



1 there were 151. Present estimates, based on the number now  
2 in training and future prospects, indicate that in 1970  
3 there will be a further decrease to 134.

4 53. It is recommended therefore, that the  
5 Federal Government subsidize dental students for service  
6 to the civilian population at the same rate that it now  
7 supports R.C.D.C. undergraduates to supply treatment to  
8 service personnel.

9 54. Section 4 - It is recommended that  
10 undergraduate and post-graduate education be carried out  
11 by the profession in the effective utilization of auxiliary  
12 personnel, particularly dental nurses and Hygienists. It  
13 is further recommended that the maximum use be made of  
14 auxiliary personnel to increase the possible volume of  
15 services.

16 55. Section 5 - It is suggested to the pro-  
17 fession that group practices be established, where feasible,  
18 for economy on expensive equipment, and communication of  
19 ideas. This would, also, improve efficiency by making it  
20 practical to employ a full-time Hygienist and dental tech-  
21 nician to work with the group.

22 56. Section 6 - It is recommended that  
23 better facilities be provided for dental diagnosis and  
24 treatment in hospitals.

25 57. Section 7 - Since the fluoridation of  
26 communal water supplies has been universally accepted by  
27 the dental profession as a deterrent to dental caries, it  
28 is recommended that the Federal Government, as an incentive  
29 to Municipalities to its more widespread use, reimburse  
30 them for the cost of maintenance of such fluoridation.



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service personnel.

54. Section I - It is recommended that

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by the profession in the effective utilization of auxiliary

personnel, namely, dental nurses and Hygienists.

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55. Section II - It is suggested to the pro-

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for economy on expensive equipment, and communication of

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practical to employ a full-time Hygienist and dental tech-

nician to work with the group.

56. Section III - It is recommended that

better facilities be provided for dental diagnosis and

treatment in hospitals.

57. Section IV - Since the fluoridation of

to participate to its more widespread use, reminder

them for the cost of maintenance of such fluoridation.





1 This would effect a considerable saving in the future costs  
2 of dental health services.

3 58. Section 8 - Since the maintenance of  
4 quality is essential in any expansion of volume of services,  
5 it is recommended that the Government proceed slowly in  
6 the matter of expansion of treatment services until such  
7 time as adequate professional personnel can be trained.  
8 The first thing to do is to stimulate training programs.  
9 At the same time, if the profession is to be made attrac-  
10 tive to prospective dentists, some assurance should be  
11 given by the Government that the standards of the profes-  
12 sion will not be lowered. Better protection should be  
13 given, also, than is now afforded, against illegal prac-  
14 tice.

15 59. Section 9 - Dental health education has  
16 been carried out by the Dental Association and the Provin-  
17 cial Department of Health for many years. Benefits from  
18 this have been frustrated, particularly in the rural areas,  
19 by the difficulty of obtaining the treatment recommended.  
20 However, it is recommended that educational efforts be  
21 continued, particularly from the preventive angle, communal  
22 fluoridation, and diet.

23 60. Section 10 - It is recommended, to  
24 stimulate post-graduate courses by dentists, that the  
25 expenses incurred in taking such courses, be allowed as a  
26 business expense, deductible for income tax purposes.

27 61. (C) TERMS OF REFERENCE:

28 The correlation of any new or improved pro-  
29 gram with existing services with a view to providing  
30 improved health services.



58. Section 8 - Since the maintenance of

quality is essential in any expansion of volume of services, the matter of expansion of treatment services until such time as adequate professional personnel can be trained. The first thing to do is to stimulate training programs. At the same time, if the profession is to be made attractive to prospective dentists, some assurance should be given by the Government that the standards of the profession will not be lowered.

59. Section 9 - Dental health education has

been carried out by the Dental Association and the Provisional Dental Council. There have been frictions, particularly in the rural areas, by the difficulty of obtaining the treatment recommended. However, it is recommended that educational efforts be continued, particularly from the preventive angle, community fluoridation, and diet.

60. Section 10 - It is recommended, to

expenses incurred in taking such courses, be allowed as a business expense, deductible for income tax purposes.

61. (c) TERMS OF REFERENCE:

The correlation of any new or improved program with existing services with a view to providing improved health services.





1                   Section 1 - Any new program should be an  
2 expansion of present Provincial or Municipal Health Organi-  
3 zations. If it is meant to replace them, this should be  
4 done in an orderly and co-operative manner. The nucleus  
5 of organized health services is the community, and while  
6 services require central direction, community co-operation  
7 is essential. Any new program must be flexible, and be  
8 able to adjust itself to the local needs of the type of  
9 community or rural area involved.

10                   62. Section 2 - The present Provincial  
11 Mental Health activities in the rural areas are largely  
12 educational. This education in dental care should be  
13 supplemented by treatment for the school children, to whom  
14 it is largely unavailable at the present time. A treatment  
15 program, however, is impossible at the present time and  
16 must await the provision of professional staff by a stepped-  
17 up training scheme.

18                   63. Section 3 - The objective laid down in  
19 the terms of reference is a major effort and it is presumed  
20 that it is intended to be operated in a national manner.  
21 No contributory dental health insurance schemes are in  
22 operation in Nova Scotia. No doubt the Commission will  
23 have available the costs of such insurance. These costs  
24 can be compared with those for comprehensive dental care  
25 under publicly-operated treatment programs in Canada.  
26 Ontario has school dental treatment. The Department of  
27 Veterans' Affairs, for an extended period, has been  
28 supplying treatment to two other age groups, distinct in  
29 character; the recipients of War Veterans' Allowance, and  
30 the Royal Canadian Mounted Police.





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1                   The average cost per individual per year in  
2 these groups could be easily obtained and compared with  
3 the cost of privately-operated Dental Health Insurance.  
4 Treatment administered under the D.V.A. is partly by  
5 clinics and partly by dentists of choice under the fee  
6 system. This seems a good example of a flexible system  
7 of operation.

8                   64. Section 4 -- As already stated, any  
9 noteworthy expansion of treatment services requires a  
10 corresponding increase in the number of professionally  
11 trained treatment personnel, dentists, and dental Hygie-  
12 nists. To achieve planned and systematic results this  
13 training must be subsidized.

14                   65. When Newfoundland entered Confederation  
15 the need for additional Dental Health services was urgent.  
16 The Provincial Government instituted a subsidization plan  
17 for dental students. During the past nine years this plan  
18 has resulted in sixteen of the seventeen Newfoundland  
19 graduates in Dentistry from Dalhousie returning to Newfound-  
20 land to practice. By the terms of their contract the first  
21 two years of this service would be rendered in a rural area  
22 designated by the Minister of Health. They are assisted  
23 with equipment on loan from the Department to the value  
24 of \$3,000.00, with rental assistance up to \$50.00 per month.  
25 They are, also, paid up to \$3,600.00 per year for half-time  
26 dental work for school children.

27                   66. The assistance to training is a flat  
28 sum of \$1,200.00 annually for each of the four years in  
29 the Dental School. This debt is cancelled after four  
30 years return of service to the Province. The last two



The average cost per individual per year in these groups could be easily obtained and compared with the cost of privately-operated Dental Health Insurance. Treatment administered under the D.V.A. is partly by system. This seems a good example of a flexible system of operation.

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66. The assistance to training is a last sum of \$1,200.00 annually for each of the four years in the Dental School. This debt is cancelled after four years return of service to the Province. The last two





1 years of this may be spent in completely independent prac-  
2 tice if the dentist does not wish to continue school  
3 services.

4 67. This program is highly commendable.

5 As a new Province Newfoundland blazed the way with a far-  
6 sighted plan of Dental Health. This plan, which displays  
7 a deep sense of social consciousness, is hard-headed and  
8 practical. It has produced profound results, in that the  
9 dental-population ratio of Newfoundland is now 1:10,000,  
10 where ten years ago it was 1:20,000. In this, Newfound-  
11 land is unique in Canada, whereas the dentist-population  
12 ratio in all the other Provinces has deteriorated. It is  
13 recommended that this plan be studied by the Commission as  
14 a basis for a National program for augmenting Health ser-  
15 vices.

16 68. It is not considered desirable that  
17 non-contributory Dental Health Insurance be instituted in  
18 Canada for anybody except pre-school age and school age  
19 children and the indigent. Even for school-age children,  
20 it is felt that some small contribution from community  
21 organizations would ensure better co-operation with treat-  
22 ment facilities. Adult treatment should be contributory,  
23 especially for the replacement of lost teeth. This would  
24 not only lower the cost to the insurer, but divide the  
25 responsibility and increase the appreciation of the reci-  
26 pient for the service. Even in the case of Old Age  
27 Pensioners, some fraction of the cost of the replacement  
28 of dentures should be contributory.

29 69. Section 5 - An objection to the effi-  
30 ciency of full-time employment of dentists in school



time if the dentist does not wish to continue school services.

67. This program is highly commendable. As a new Province Newfoundland placed the way with a far-  
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non-contributory Dental Health Insurance be instituted in  
Canada for anybody except pre-school age and school age  
children and the indigent. Even for school-age children,  
it is felt that some small contribution from community  
organizations would ensure better co-operation with treat-  
ment facilities. Adult treatment should be contributory,  
especially for the replacement of lost teeth. This would  
not only lower the cost to the insurer, but divide the  
responsibility and increase the appreciation of the re-  
cipients for the service. Even in the case of Old Age  
Pensioners, some fraction of the cost of the replacement  
of dentures should be contributory.

69. Section 5 - an objection to the estab-  
lishment of full-time employment of dentists in schools





1 clinics is that after school hours little use is made of  
2 the clinic. In our rural areas particularly where services  
3 are in short supply, such a clinic could be operated to  
4 advantage five hours per day on school children and the  
5 remaining two hours on adults.

6 70. Section 6 - It necessarily follows that  
7 any improved treatment service will maintain and improve  
8 standards. Salaries should be maintained at a level  
9 which will maintain the morale of the employees. Career  
10 professional employees should be diplomats in Public  
11 Health. Naturally their salaries should be in a different  
12 category than short-time employees, who have enjoyed the  
13 benefits of a subsidized education primarily for private  
14 practice.

15 71. Section 7 - Any new or improved program  
16 should include the wider use of dental Hygienists working  
17 under the direct supervision of a Dentist. In this way  
18 the scope of their usefulness can be broadened, as well  
19 as improved by consultation.

20 72. While a better quality of service is  
21 provided by the larger laboratories in the more specialized  
22 fields of prosthetic dentistry, in other phases of this  
23 service efficiency is greatly improved by having the tech-  
24 nician in close proximity to, and working in close co-opera-  
25 tion with, the Dentist. As treatment services are  
26 expanded, this should be borne in mind.

27 73. Section 8 - It should be stressed that  
28 early and regular dental maintenance, especially if  
29 combined with other preventive measures, will radically  
30 reduce the cost of dentistry to the individual within his





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71. Section 7 - Any new or improved program should include the wider use of dental hygienists working under the direct supervision of a dentist. In this way the scope of their usefulness can be broadened, as well as improved by consultation.

72. While a better quality of service is provided by the larger laboratories in the more specialized fields of prosthetic dentistry, in other phases of this service efficiency is greatly improved by having the technician in close proximity to, and working in close cooperation with, the dentist. As treatment services are expanded, this should be borne in mind.

73. Section 8 - It should be stressed that early and regular dental maintenance, especially if combined with other preventive measures, will radically reduce the cost of dentistry to the individual within his



1 life span. It is cheaper in the long run to save the  
2 natural teeth in this way than to obtain expensive replace-  
3 ments. Research statistics on this matter are urgently  
4 needed as part of an educational campaign to the Public.

5 74. (D) The present and future requirements  
6 of Personnel to provide health services.

7 1. One statistical record which we do have  
8 showing the dental condition of a large group is that of  
9 the West Nova Scotia Regiment. This Regiment, recruited  
10 in 1939, consisted of (730) all ranks. It required the  
11 extraction of (3300) teeth, the insertion of (1800)  
12 fillings, and the supply (350) dentures to comply with the  
13 Army Dental requirements for fitness to proceed overseas.  
14 It may be said that economic conditions and highways are  
15 better today. That is true, but on the other hand, today,  
16 Dentists are fewer and the population has increased,  
17 leaving the results about the same.

18 75. What is the picture of the dentist-popu-  
19 lation ratio today? In the report of the Nova Scotia  
20 Dental Association, printed in June 1960, the Dental  
21 Register for 1959 shows (235) dentists. A careful check  
22 of this register indicates that of these, only 151 are in  
23 private practice. A careful check of the 1949 report, done  
24 at the same time, and in the same way, by competent autho-  
25 rity, shows a total of 209 Dentists on the register for  
26 1948, of whom 177 were in private practice. The seeming  
27 disparity is made up by a great deal more Dentists being  
28 in the public service, or retired, at the present time.  
29 This makes a net loss in privately practising Dentists of  
30 26. During the same period the population of the Province



life span. It is cheaper in the long run to save the

ments. Research statistics on this matter are unobtainable

needed as part of an educational campaign to the public.

74. (D) The present and future development

of personnel to provide health services.

1. One statistical record which we do have

showing the dental condition of a large group is that of

the West Nova Scotia Regiment. This Regiment, recruited

in 1939, consisted of (750) all ranks. It was found that

extraction of (3300) teeth, the insertion of (1000)

fillings, and the supply (350) dentures to comply with the

Army Dental requirements for fitness to proceed overseas.

It may be said that economic conditions and highways are

better today. That is true, but on the other hand, today

Dentists are fewer and the population has increased.

of this register indicates that of those, only 177 are in

private practice. A careful check of the 1940 report, shows

at the same time, and in the same way, by comparison with

now, shows a total of 209 Dentists on the register for

1945, of whom 177 were in private practice. The remaining

disparity is made up by a great deal more Dentists being

in the public service, or retired, at the present time.

It makes a net loss in privately practicing dentists of

20. During the same period the population of the Province





1 increased by 103,000.

2 76. 2. At the present time, there are  
3 nine dental Hygienists registered in the Province and, of  
4 this number, five are engaged in the Public Health service.  
5 It has been necessary for these auxiliaries to obtain  
6 their training at the University of Toronto up until this  
7 year, when a school of Dental Hygiene was started at  
8 Dalhousie University.

9 77. 3. Nova Scotia requires ten additions  
10 to the dental population each year to counteract the  
11 present unfavorable dentist-patient ratio. By 1990,  
12 this would provide a dentist-population ratio, with an  
13 increase of dental auxiliaries as well, that would provide  
14 reasonably adequate comprehensive service.

15 78. 4. Dental education in the schools  
16 would appear to be the way to prevent the complicated  
17 and expensive dental problems of the adult. With the  
18 known preventive measures which are available and their  
19 effectiveness having been proven, it would appear that  
20 more extensive dental health education should be given in  
21 our schools by auxiliaries such as the Dental Hygienists.

22 79. 5. A definite need exists for the  
23 provision of treatment services to handicapped children,  
24 e.g. those suffering from oral clefts and dentofacial  
25 anomalies requiring orthodontic treatment. Personnel  
26 capable of rendering this service require specialized  
27 training after graduation from Dental School. This  
28 entails a large capital outlay and it would appear evident  
29 that if treatment services are to be made available to  
30 children having these anomalies that more men in these



76. 2. At the present time, there are

nine dental Hygienists registered in the Province and, of  
this number, five are engaged in the Public Health service.  
It has been necessary for these auxiliaries to obtain  
their training at the University of Toronto as well as  
year, when a school of Dental Hygiene was started at

77. 3. Nova Scotia requires ten assistants

for the dental profession each year to compensate for  
present unfavorable dentist-patient ratio. By 1960,  
this would provide a dentist-population ratio, which is  
increase of dental auxiliaries as well, that would provide  
reasonably adequate comprehensive services.

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would appear to be the way to prevent the complicated  
and expensive dental problems of the adult. With the  
known preventive measures which are available and their  
effectiveness having been proven, it would appear that  
more extensive dental health education should be given in  
our schools by auxiliaries such as the Dental Hygienists.

79. 5. A definite need exists for the

provision of treatment services to hospitalized children,  
e.g. those suffering from oral clefts and hereditary  
anomalies requiring orthodontic treatment, hereditary  
conditions of rendering this service requires specialized  
training after graduation from Dental School. There

that if treatment services are to be made available to  
children having these anomalies that more may be done





1 specialties will have to be provided and also that compen-  
2 sation for their services will have to be adequate to  
3 attract them.

4 80. (E) Methods of providing adequate  
5 personnel with the best possible training and qualifica-  
6 tions for such services.

7 1. Active recruitment programs for more  
8 dental students.

9 81. 2. Financial assistance to students  
10 coming from the lower income groups who have the academic  
11 qualifications but are unable to undertake University  
12 studies because of lack of funds. These students to  
13 receive assistance at the pre-dental level.

14 82. 3. Endeavour to attract women to the  
15 profession.

16 83. 4. Increase in number of auxiliaries,  
17 particularly, dental Hygienists.

18 84. 5. Expansion of activities now legally  
19 permitted to Hygienists.

20 85. 6. Establishment of manned dental  
21 clinics in accredited Hospitals.

22 86. 7. Make salaries adequate to attract  
23 personnel in the Public Health Field.

24 87. (F) The present physical facilities  
25 and the future requirements for the provision of adequate  
26 health services:

27 1. Population of Nova Scotia (Canada Year  
28 Book - 1960)

29 1951 - 642,584;

(Rural - 295,623

30 1956 - 694,717 (Urban - 399,094 - communities





specialists will have to be provided and also that con-  
sultation for their services will have to be arranged to

80. (E) Methods of providing services

personnel with the best possible training and qualifica-  
tions for such services.

81. Active recruitment programme for more

81. 2. Financial assistance to students

coming from the lower income groups who have the academic  
qualifications but are unable to undertake university  
studies because of lack of funds. These students to  
receive assistance at the pre-dental level.

82. 3. Endeavour to attract women to the

profession.

83. 4. Increase in number of auxiliaries

84. 5. Extension of activities now largely

permitted to Hygienists.

85. 6. Establishment of manned dental

clinics in accredited hospitals.

86. 7. Make salaries attractive to attract

personnel in the Public Health field.

87. (F) The present physical facilities

and the future requirements for the provision of adequate

health services:

1. Population of New Guinea (1950-1955)

(1950 - 1955)



over 1,000 pop.

(Rural - Est. 300,000

1961 - Est. 750,000 (Urban - Est. 450,000

88. 2. Physical facilities available at

present to provide dental care include private offices

furnished by the practising Dentists in Nova Scotia,

which are presently adequate for the personnel now avail-

able. With increased auxiliary help these facilities

would have to be expanded. In addition, treatment faci-

lities are available in Federal Hospitals and other

establishments for Veterans, War Veterans' Allowance reci-

ipients and members of the Armed Services. These latter

provide care for 2-3% of the total population.

89. 3. In the 65 Public Hospitals in Nova

Scotia including mental Hospitals there are some facilities

for Dental treatment in some Hospitals. However, in most

cases, there is no provision for rendering dental care

and where facilities are available there is no dental

staff provided.

90. 4. In the recently constructed conso-

lidated and rural secondary schools, there has been no

provision of facilities for dental care. In at least one

City there are dental facilities provided in one of two

schools.

91. 5. Facilities to provide adequate

dental care for an expanding population will have to be

greatly increased.

92. 6. An increase in the number of

privately practising Dentists will result in an increase

in private facilities provided by the Dentist.

93. 7. Except in the event of a National







1 emergency facilities in the Federally-operated establish-  
2 ments would appear to be adequate to the foreseeable need.

3 94. 8. Facilities for dental care should  
4 be provided in public Hospitals with provision for adequate  
5 staff to operate them.

6 95. 9. Facilities for dental care could be  
7 provided in regional and rural schools which could be used  
8 for care of school-aged children as well as for adult popu-  
9 lation of the respective area.

10 96. (G) 1. There is no reliable source of  
11 information relative to the amount spent in Nova Scotia on  
12 dental care.

13 97. 2. The capital cost involved in provi-  
14 ding facilities for dental care in Public Hospitals and  
15 schools would be very small relative to the total capital  
16 expenditure involved.

17 98. The present methods of financing dental  
18 services are as follows:

19 1. By private agreement between patient and  
20 dentist.

21 2. By CDSPI - a post-payment plan sponsored  
22 by dental organizations.

23 3. Free dental care by the dentists.

24 4. Welfare agencies, e.g. D.V.A.; War  
25 Veterans' Allowance; Children's Aid Socie-  
26 ties; Private and Public Institutions; Junior  
27 Red Cross; Service Clubs.

28 5. Provincial Department of Health and  
29 Welfare, e.g. Rural Mobile units on a limited  
30 scale.



to be provided in public hospitals with provision for attendance  
staff to operate them.

96. Provisions for dental care would be  
provided in regional and rural hospitals which could be used  
for care of school-aged children as well as for adult population  
of the respective areas.

97. I. There is no reliable source of  
dental care.

98. The capital cost involved in providing  
dental care would be very small, relative to the total capital

99. The present method of financing dental  
services are as follows:

1. By private agreement between patient and  
dentist.

2. By Government - a poor patient pays a small  
sum for dental treatment.

3. Free dental care by the Government.

4. Welfare agencies, e.g. D.V.A., etc.

5. Voluntary organizations; e.g. D.V.A., etc.

6. Private and public institutions; e.g. D.V.A., etc.

7. Government; e.g. D.V.A., etc.

8. Government; e.g. D.V.A., etc.

9. Government; e.g. D.V.A., etc.



1 had y needed. 6. A.D.A. plan with The Continental Casualty  
2 Co. (see index H - I). There are very limi-  
3 ted pre-paid insurance schemes or Labor-  
4 Health, or Management Agreements to cover Dental  
5 Services in Nova Scotia.  
6 99. The methods of financing present, new  
7 and extended dental services must be the  
8 responsibility of the whole community. Yet,  
9 it is important that the principle of individual  
10 and decreased responsibility be maintained.

11 Four (4) basic fields of Dentistry must be  
12 considered:- Education; Administration; Treatment; Research.

13 100. EDUCATION: Since Dental Personnel move  
14 from Province to Province, or study in other than their  
15 home Province, and since many R.C.D.C. personnel are being  
16 educated for National Service, Federal subsidization is  
17 essential to Dental Education. This aid must be to the  
18 Universities and to the students, and also to graduates  
19 who pursue further studies - see Index re grants. Not  
20 only should direct aid be made, but long-term, interest-  
21 free loans should be made available. Terms and conditions  
22 for aid should result in mutual benefits to the student  
23 and to the Public - see Index re Newfoundland plan.

24 101. PUBLIC HEALTH EDUCATION: The Medical  
25 Profession is fortunate in having many aids from laymen  
26 groups, e.g., Arthritis Society, Heart Foundations, etc.  
27 Dentistry, which is not a "dramatic" disease, but consi-  
28 derably more prevalent than any other, needs positive help  
29 in educating the public. This is especially true in fields  
30 of prevention. National help via National facilities is



2. A.D.A. plan with The Continental Casualty Co. (see index H - I). There are very limited pre-paid insurance schemes or labor-

Services in New Zealand.

3. The methods of financing present, new

and extended dental services must be the

responsibility of the whole community. Yet,

it is important that the principle of individual

responsibility be maintained.

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considered: - Education; Administration; Treatment; Research.

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15. home Province, and since many R.D.C. personnel are being

16. educated for National Service, Dental education is

17. essential to Dental Education. This aid must be to the

18. Universities and to the students, and also to graduates

19. who pursue further studies - see Index re grants. Not

20. only should direct aid be made, but long-term, interest-

21. free loans should be made available. Terms and conditions

22. for aid should result in mutual benefits to the student

23. and to the Public - see Index re New Zealand plan.

101. PUBLIC HEALTH EDUCATION: The Medical

24. profession is fortunate in having many aids from private

25. groups, e.g., Arthritis Society, Heart Foundations, etc.

26. dentistry, which is not a "chronic" disease, but con-

27. sidered the "silent" killer. This is because it is

28. the commonest cause of death in New Zealand.



1 badly needed.

2 102. ADMINISTRATION: The severe neglect of  
3 dentistry by both Federal and Provincial Departments of  
4 Health, or at least those responsible, has resulted in an  
5 extreme shortage of trained Administrators (both dental  
6 and non-dental) for any Publicly-assisted Dental-Health  
7 Plan.

8 103. Those personnel which are available  
9 are extremely underpaid, and have been surprisingly loyal  
10 and dedicated.

11 104. It is essential that from the ranks of  
12 our dental and non-dental students, and from the ranks of  
13 the profession itself, interested and dedicated personnel  
14 must be selected and trained for the rapidly expanding  
15 field of Dentistry.

16 105. Their training must be publicly paid for,  
17 and this may include foreign training as well, and when  
18 they return, it must be to work with a willing and able  
19 Governmental agency for the Public Welfare.

20 106. TREATMENT: The basic objective must  
21 be comprehensive treatment being made available for every  
22 citizen. However, since personnel is in very short supply  
23 -- and demand on its time is very heavy, priorities are  
24 essential - (see K. below).

25 107. We therefore urge that the principle  
26 of public aid for comprehensive dental care be established,  
27 following the outline of priorities listed elsewhere. As  
28 our Society attains the means of expanding these services,  
29 so will ever larger groups of our population be included.  
30 Since we believe that the concept of personal responsibility



The severe neglect of

dentistry by both Federal and Provincial Departments of Health, or at least those responsible, has resulted in an extreme shortage of trained Administrators (both dental and non-dental) for any Publicly-assisted Dental-Health Plan.

103. These personnel which are available are extremely unskilled, and have been surprisingly few in number and dedicated.

104. It is essential that from the ranks of our dental and non dental students, and from the ranks of the profession itself, increased and dedicated personnel must be selected and trained for the rapidly expanding field of Dentistry.

105. Their training must be publicized for, and this may include foreign training as well, and when they return, it must be to work with a willing and able

106. TERMINAL: The basic objective must be comprehensive treatment being made available for every citizen. However, since personnel is in very short supply -- and demand on the time is very heavy, priority has to be essential - (see K. below).

107. We therefore urge that the principles of public aid for comprehensive dental care be established following the outline of principles stated elsewhere. As our Society attains the means of expanding these services, we will serve larger groups of our population be trained. Since we believe that the concept of personal responsibility





1 be maintained, we suggest that a scale of aid be devised  
2 for comprehensive dental care - (see Index, e.g., more aid  
3 for lower income groups, and scaled upwards accordingly).

4 108. This can also be bolstered by aid to  
5 the Dentist and benefit to the Public viz:

- 6 1. Public aid in the capitalization of  
7 equipment, e.g., Physicians render services  
8 in Hospitals equipped at Public expense.
- 9 2. Public aid in the heavy costs of a Dental  
10 Education. Not only subsidies, but a 20-year  
11 write-off of educational costs.
- 12 3. Government aid in insuring the Dentist  
13 in the event of illness or accident, espe-  
14 cially due to his very high overhead, e.g.,  
15 Dental 50%; Medical 25% including car.
- 16 4. Help in developing some Centralized  
17 Accounting and statistical system, to permit  
18 more productive time by the Dental profession.

19 109. The best treatment is prevention -  
20 and this means early interceptive measures. It is agreed  
21 by all of Dentistry that our concentrated efforts be  
22 focused on our children, so that in time, the dental  
23 problem of our adults will be greatly reduced.

24 110. Prevention - Fluoridation of ALL Muni-  
25 cipal water supplies is essential, and public aid must be  
26 proffered. The cost is extremely low relative to the  
27 benefits to be derived - (see Index -- Fluoridation bene-  
28 fits and Fluoridation costs). This proven and most bene-  
29 ficial health aid (which may be compared with the iodizing  
30 of salt, which is mandatory) has become an emotional

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2 for comprehensive dental care - (see Index, e.g., more aid  
3 for lower income groups, and scaled upwards accordingly).  
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6 equipment, e.g., Physicians render services  
7 in Hospitals equipped at Public expense.  
8 2. Public aid in the heavy costs of a Dental  
9 Education. Not only salaries, but a 20-25%  
10 write-off of educational costs.

11 3. Government aid in training the Dentists  
12 in the event of illness or accident, espe-  
13 cially due to his very high overhead, e.g.,  
14 Dental 50%; Medical 25% including car.

15 4. Help in developing some centralized  
16 Accounting and statistical system, to permit  
17 more productive time by the Dental professional.  
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19 and this means early interceptive measures. It is agreed  
20 by all of Dentistry that our concentrated efforts be  
21 focused on our children, so that in time, the dental  
22 problem of our adults will be greatly reduced.

23 110. Prevention - Fluoridation of the Water  
24 Fluoridation of the water supply is essential, and public aid must be  
25 provided. The cost is extremely low relative to the  
26 practice to be derived - (see Index - Fluoridation bene-  
27 fits and Fluoridation costs). This proven and now bene-  
28 ficial health aid (which may be compared with the Federal  
29 aid, which is mandatory) has become an essential





1 football. It should be re-classified. It has been recom-  
2 mended by ALL Governmental Departments of Health for years.  
3 Public aid to communities must be offered as incentives.

4 111. Topical applications of anti-decay  
5 solutions - especially important in rural areas, must be  
6 vastly increased. At present, our Department of Dental  
7 Health is doing this on a limited scale.

8 112. RESEARCH: Dental Research is practi-  
9 cally nil in Nova Scotia. Only recently has the University  
10 started some, on a small scale.

11 113. It is conceivable that if substantial  
12 Public funds were diverted to serious Dental Research,  
13 that future needs for treatment could be greatly reduced.  
14 Caries is the most prevalent disease today.

15 114. To this day, the entire mechanism of  
16 decay is not fully understood - (if it were our brief  
17 might not be required).

18 115. Private practitioners who would like  
19 to do research cannot afford to do so, and we can do no  
20 more than point out this serious deficiency in our Province,  
21 and we believe, in all of Canada.

22 116. Each Provincial Laboratory of the  
23 National Research Council should be equipped for Dental  
24 Research - both with equipment and personnel, to work in  
25 collaboration with Universities and Hospitals and the  
26 Medical and Dental Professions. Here we would have the  
27 association with Chemists, Physicists, Biologists and  
28 Engineers, so that the Field of Dentistry will not remain  
29 isolated. Close collaboration with the Provincial Depart-  
30 ments of Health, statisticians, etc., is also thus



and we believe, to all of them.



1 feasible.

2 See also Section 1 - Research.

3 117. THE FEASIBILITY AND DESIRABILITY OF  
4 PRIORITIES IN THE DEVELOPMENT OF HEALTH CARE SERVICES.

5 If a dental health program is to be instituted that will  
6 provide comprehensive treatment for everyone, then incre-  
7 mental care is the only sound approach, due to high costs  
8 and unavailability of personnel at the present time.

9 118. While our objective remains to provide  
10 eventually comprehensive treatment for all, it should not  
11 be done at the expense of those who have been provided  
12 with comprehensive care through the years. Care for the  
13 whole population should start with a preferred segment  
14 (children considered the most deserving) and gradually  
15 extend to include a larger and larger segment of the  
16 population - (See Index k - 1). As an alternative, a  
17 health program could provide a minimal service to the  
18 whole populace and encourage them to provide the balance  
19 of the service at their own expense. The solution may lie  
20 in a combination of the above, such as providing relief  
21 of pain and infection for all and then adding services to  
22 the children's group, and finally to the other groups as  
23 the need exists and funds and personnel become available.

24 119. The general principle of levying taxes  
25 in general and spending specifically would have to be  
26 followed, as to do the greatest good for the greatest  
27 number, based on a long range plan. It should also be  
28 expressly implied that a dentist is entitled to contract  
29 with the patient for services not covered by the Public  
30 aid, and must make his own collections for such services.

See also Section I - Discussion.

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3 provide comprehensive treatment for everyone, then in-  
4 mental care is the only sound approach, due to high costs  
5 and unavailability of personnel at the present time.  
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10 whole population should start with a preformed segment  
11 (children considered the most deserving) and gradually  
12 extend to include a larger and larger segment of the  
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14 health program could provide a minimal service to the  
15 whole population and encourage them to provide the balance  
16 of the service at their own expense. The solution may lie  
17 in a combination of the above, such as providing relief  
18 of pain and infection for all and then adding services to  
19 the children's group, and finally to the other groups as  
20 the need arises and funds and personnel become available.  
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24 number, based on a long range plan. It should also be  
25 expressly implied that a dentist be entitled to consult  
26 with the patient for services not covered by the Public  
27 aid, and must make his own collections for such services.





1 It must also be made clear to the public that they are  
2 responsible for the cost of "uninsured" services and that  
3 fully extended services cannot be provided without a  
4 further increase in taxation. This will also permit those  
5 who have maintained the best possible dental care to con-  
6 tinue to provide this level of care for themselves and  
7 their families.

8 INDEX H - I

9  
10 Chicago, Sept. 1-- Employees of the American  
11 Dental Association will be covered by dental insurance,  
12 starting January 1, 1962, it was announced today by Dr.  
13 Harold Hillenbrand, Association Secretary.

14 The insurance program is similar to the  
15 pioneering plan established in 1959 for the employees of  
16 Dentists' Supply Company, York, Pa. In a two-year report  
17 issued recently by the company the plan was termed a  
18 "complete success". The cost of dental services performed  
19 under the plan, including the portion paid by the employee  
20 was \$138,000 over the two years.

21 The A.D.A. insurance program will be operated  
22 by the Continental Casualty Company, as is the Dentists'  
23 Supply plan and a third program operated for employees of  
24 the Kerr Manufacturing Company.

25 Under the Association program, all types of  
26 dental services are covered with the exception of purely  
27 cosmetic dentistry or services covered by other health  
28 insurance. Any licensed dentist may be chosen, and he may  
29 charge his customary fee: there is no fee schedule or table  
30 of allowances. All full-time Association employees and



It must also be made clear to the public that they are responsible for the cost of "uninsured" services and that fully extended services cannot be provided without a further increase in taxation. This will also permit those who have maintained the best possible dental care to continue to provide this level of care for themselves and

JOHN H. - I

Chicago, Sept. 1 -- Improvements of the American Dental Association will be covered by dental insurance, starting January 1, 1962, it was announced today by Dr. The insurance program is similar to the pioneering plan established in 1959 for the employees of Continental Supply Company, York, Pa. In a two-year report issued recently by the company the plan was termed a "complete access". The cost of dental services performed under the plan, including the portion paid by the employee, was \$38,000 over the two years. The A.D.A. insurance program will be controlled

by the Continental Casualty Company, as is the Dental Supply plan and a third program operated for employees of Under the Association program, all types of dental services are covered with the exception of purely cosmetic dentistry or services covered by other health insurance. Any licensed dentist may be chosen, and he may charge his customary fee; there is no fee schedule or table of allowances. All full-time Association employees and





1 their dependants are covered, 375 persons in all.

2 The Association will pay the entire annual  
3 premium, amounting to approximately \$100.00 per employee,  
4 in order to ensure full participation.

5 INDEX K - L

6 SECTION "A"

7 This implies the adoption of a general objec-  
8 tive capable of incremental implementation over a period of  
9 years and a clear understanding by dentists, patients, and  
10 Government of precisely the benefits which are available  
11 from time to time. The following sequence is commonly  
12 employed and might be adopted by the profession generally.

- 13 (1) Examination - consultation - preventive  
14 measures at individual and community level.
- 15 (2) Relief of pain.
- 16 (3) Treatment of infections.
- 17 (4) Elimination of caries - plastics, porce-  
18 lain and precious metals.
- 19 (5) Restoration of lost and mutilated  
20 occlusion - partials, fixed bridges and  
21 complete dentures.
- 22 Clinical research - special benefits in  
23 special cases limited to 1% or 10% of budget.

24 SECTION "B"

25 Priorities could also be implemented by  
26 means of social groups:

- 27 (1) Children - preschool.
- 28 (2) Children - common school.
- 29 (3) Indigent - in receipt of welfare.
- 30 (4) Unemployed but employable.



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3 premium, amounting to approximately \$100.00 per employee.

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9 government of precisely the benefits which are available

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11 employed and might be adopted by the profession generally.

12 (1) Examination - consultation - prevention -

13 measures at individual and community level.

14 (2) Relief of pain.

15 (3) Treatment of infections.

16 (4) Elimination of caries - gingivitis, periodontitis,

17 pain and precious metals.

18 (5) Restoration of lost and mutilated

19 occlusion - dentures, fixed bridges and

20 complete dentures.

21 Clinical research - special benefits in

22 special cases limited to 25 or 10% of budget.

23 Priorities could also be implemented by

24 a series of special groups.

25 (1) Children - preschool.

26 (2) Children - common school.

27 (3) Indigent - in respect of welfare.

28 (4) Unemployed and employed.



(5) Unemployed and unemployable.

(6) Aged.

(7) Pensioned persons.

(8) High School and University students.

(9) All persons.

Also a plan could be devised to combine certain desired phases of Section A and Section B. Consideration of these principles could lead to total comprehensive care and a minimum of dislocation as these several levels of treatment were authorized. It is anticipated that the changes would take place over a considerable period of time.

ADA DENTAL INSURANCE PLAN - Add 1

The employee does participate in the cost of dental care:

\*\*In the first policy year there is a \$25 deductible factor, the employee paying the first \$25 of any dental bill, and the insurance company paying 80 per cent of everything over that amount up to a maximum of \$200.

\*\*When an employee or dependant received a routine oral examination - no more often than twice each year - he pays 20 per cent of the dentist's fee and the insurance company pays the remaining 80 per cent. The deductible factor does not apply to these semi-annual checkups.

\*\*In the years after the first year, the deductible factor drops to \$10; the 80% - 20% formula remains the same.



(b) Employees and independent contractors

(c) Agents

(d) Other persons

High School and University students

All persons

be devised to comply with certain conditions

to be determined by the Board of Directors

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ALL PARTIAL EMPLOYMENT PLAN - Add 1

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first \$25 of any dental bill, and the insur-

ance company paying 80 per cent of every-

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positive oral examination - no more often

than twice each year - he pays 20 per cent

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deductible factor does not apply to these

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deductible factor drops to \$10; the 80% - 20%

formula remains the same.





1           \*\*Maximum payments per individual are \$200  
2           the first year, \$300 the second, and \$400  
3           thereafter. Maximum payments per family are  
4           \$500 the first year, \$750 the second, and  
5           \$1,000 thereafter.

6           \*\*In the first year, the total deductible  
7           any one family will have to pay is limited  
8           to \$75; thereafter, the limit is \$30.

9           \*\*The only exceptions to the 80% - 20% for-  
10          mula are orthodontics and full dentures.

11          In each of these areas, the insurance company  
12          pays 60%, the employee 40%. There is also a  
13          maximum limit of \$400 to be paid by the  
14          company on any one orthodontic case, regard-  
15          less of the number of years involved.

16 Before the dentist institutes treatment, he will be asked  
17 to submit a treatment plan to the company to serve notice  
18 that a claim is to be submitted and to aid in development  
19 of statistical data. No judgment will be exercised by the  
20 company on the plan.



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the first year, \$300 the second, and \$400

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\*\*In the first year, the total deductible

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\*\*The only exceptions to the 80% - 20% rule

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INSURED TREATMENT BENEFITS

RESEARCH PREVENTION EDUCATION

STATISTICAL, BIOLOGICAL AND CLINICAL, RESEARCH TO BE UNDERTAKEN AND EXPANDED AT ONCE.																	
ALL PROFESSIONALLY APPROVED MEASURES TO BE IMPLEMENTED, INCLUDING FLUORIDATION OF COMMUNAL WATER SUPPLIES AND TOPICAL APPLICATIONS OF CARRIES INHIBITORS.																	
PUBLIC EDUCATION BY PUBLICLY OWNED MASS MEDIA AND PUBLIC HEALTH APPOINTMENTS.																	
PROFESSIONAL EDUCATION, STUDENT SUBSIDIZATION, POSTGRADUATE AND GRADUATE SERVING OF RESEARCH AND TEACHING FOR PUBLIC HEALTH.																	
m s y n . m < - u z m i n s w o n																	
GENERAL	PARTICULAR	CHILDREN 1-5					ADOLESCENTS 6-11					TEEN-AGERS 12-16					ADULTS 17+
1. EXAMINATION CONSULTATION DIAGNOSTIC SERVICE	Radiographical, Clinical and such other procedures as may be required.	★	★	★	★	★	★	★	★	★	★	★	★	★			
2. ELIMINATION OF ACUTE PAIN	By: Surgical, Medical Endodontic, periodontal, or operative care.	★	★	★	★	★	★	★	★	★	★	★	★	★			
3. RESOLUTION OF ORAL INFECTIONS	By surgical, Endodontic, periodontal, and operative procedures.	★	★	★	★	★	★	★	★	★	★	★	★	Social groups of special need. Pensioners with devaluated incomes, indigents, unemployed, etc.			
4. ELIMINATION OF CARRIES	Requiring: Plastic materials Precious metals Porcelain	★	★	★	★	★	★	★	★	★	★	★	★	THESE			
5. RESTORATION OF LOST AND MUTILATED OCCLUSIONS	Using, crowns, bridges, partial dentures, and complete dentures.	★	★	★	★	★	★	★	★	★	★	★	★	INCREMENTS OF CARE TO BE IMPLEMENTED AS RESOURCES OF			
6. AESTHETIC IMPROVEMENT		★	★	★	★	★	★	★	★	★	★	★	★	FUNDS AND PERSONNEL PERMIT			







1 THE SECRETARY: The brief will be Exhibit  
2 No. 8.

3  
4 --- EXHIBIT NO. 8: Submission of the Nova Scotia Dental  
5 Association.

6  
7 DR. MERRITT: Mr. Chairman, members of the  
8 Commission, gentlemen, at the outset I would like to point  
9 out that this was prepared by the members of the dental  
10 profession in what we might term, their spare time. A  
11 similar survey which took place in the United States took  
12 over three years to prepare, and if there are omissions in  
13 this, I hope you will bear with us.

14 THE CHAIRMAN: That survey that you speak of  
15 in the United States, a copy of that is available?

16 DR. MERRITT: Yes sir.

17 COMMISSIONER FIRESTONE: May I have the name  
18 of the survey?

19 DR. MERRITT: Survey of Dentistry. The  
20 final report of the Commission on the Survey of Dentistry  
21 in the United States, by Byron S. Hollinshead, Director.  
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1 Mr. Chairman, if I may return to the first  
2 page, I wish to underscore two words. You have heard a  
3 number of suggestions of "subsidization", and this is one  
4 word I would like to speak a little about; and the second  
5 one is "directly".

6 We chose this word "subsidization" after  
7 some consideration. In the first place, I should like to  
8 point out that the Province of Nova Scotia is supporting  
9 dental education to a very great degree. The dental profes-  
10 sion has made scholarships and loan funds available to  
11 students. Quite frankly, sir, I think we have done about  
12 all we can do -- and the people of the Province. Industry,  
13 apparently, in Nova Scotia, does not make as much money as  
14 it does in other places in Canada. We had some trouble in  
15 the shipyard recently on this. I think the Gordon Commis-  
16 sion in its report, in its tables at the back of it, pointed  
17 out that the people of Nova Scotia pay a higher tax on cars,  
18 a higher gasoline tax than elsewhere, and income seems to  
19 be somewhat lower. If the profession and the Nova Scotia  
20 Government and the people have reached the limit of their  
21 resources, then we have to look elsewhere for funds, and  
22 that is why we chose the word "subsidization".

23 The second point is to subsidize students  
24 "directly". I believe the University brief pointed out  
25 that students enter the dental faculty after completing two  
26 years of pre-dental education, the first two years in a  
27 general college. The funds which are available for dental  
28 students are not available to these people in the pre-dental  
29 years. So, we feel the subsidization should start with  
30 the students as they enter upon the whole study of dentistry;

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1 in other words, when they complete their high school educa-  
2 tion. This is the area in which it would be most helpful  
3 in getting more students into dentistry, if they could be  
4 assured of some way of being able to complete the training  
5 at the time they are ready to enter the profession on  
6 completion of high school. That is why we feel subsidiza-  
7 tion of dental training should be made directly to the  
8 student rather than indirectly to the University.

9 THE CHAIRMAN: Do you mean by that something  
10 different from the present grant and aid to each pupil  
11 attending a university?

12 DR. MERRITT: We would not wish to supplant  
13 any of the assistance being given. This is something we  
14 would like to have as some way of encouraging them. The  
15 dental profession has established a recruiting committee  
16 to try and encourage students to enter dentistry, and we  
17 feel one of the most appropriate places to put our effort  
18 is to the student at the point he is about to enter profes-  
19 sional study.

20 THE CHAIRMAN: But when you say "directly",  
21 how would you give it to the student?

22 DR. MERRITT: You have had many suggestions  
23 previously.

24 THE CHAIRMAN: But what is the Dental Associa-  
25 tion's suggestion?

26 DR. MERRITT: The one we have is -- well, I  
27 can't find it at the moment, but what we are saying is  
28 that a system of scholarships should be set up -- scholar-  
29 ships and bursaries -- for needy students, and if there is  
30 a wish to tie this to public service, as in the Newfoundland



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1 plan, for a period, I would be quite happy to see that  
2 system followed.

3 local member. THE CHAIRMAN: Is it the viewpoint of the  
4 Dental Association that there should be this condition of  
5 staying in the Province for a certain period to any  
6 student who has accepted help in getting his education in  
7 this way?

8 brought out DR. MERRITT: We have endorsed Newfoundland's  
9 scheme. We don't feel this is the only way of doing it,  
10 and that is the reason we have not spelled out the method  
11 of subsidization. Does that answer the question?

12 brought out THE CHAIRMAN: Yes.

13 brought out COMMISSIONER VAN WART: If the money comes  
14 from a Federal source, do you still wish the student to  
15 stay in Nova Scotia?

16 brought out DR. MERRITT: If it is a Nova Scotian student  
17 who is being supported by Federal funds, I think it is  
18 reasonable to ask him to stay in Nova Scotia to serve out  
19 the time he is committed for. This school also caters to  
20 the other Atlantic Provinces, and it would not be quite  
21 fair to use Federal funds to have them all serve in Nova  
22 Scotia.

23 THE CHAIRMAN: You would have the New Bruns-  
24 wick student return to New Brunswick or the Prince Edward  
25 Island student return to Prince Edward Island?

26 brought out DR. MERRITT: Yes, but it is up to them to  
27 make their own submission. I am only talking about Nova  
28 Scotian students.

29 COMMISSIONER STRACHAN: Could you compel  
30 them to remain within the Atlantic area? Wouldn't it

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26 COMMISSIONER STEPHENSON: Could you compel

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1 still be their privilege to go to any part of Canada? I  
2 think we could confine them to Canada, but could we by any  
3 legal means confine them to a particular area?

4 ~~So not fall in~~ DR. MERRITT: As a dentist, I don't think  
5 you can confine any person in Canada to any particular area.  
6 Perhaps the Chairman could give us a legal opinion.

7 COMMISSIONER VAN WART: Dr. Merritt, you  
8 brought out a case for subsidy of the students: I wonder  
9 if you could make available to the Commission the source  
10 of financial means which the present students that are  
11 enrolled -- that is to say, the percentage that are suppor-  
12 ted by their relatives, and the percentage supported by  
13 grants and scholarships such as you mention, and those  
14 that are under life insurance schemes, and so on, etc.?  
15 If you could break it down, how those that are in your  
16 University at the present time are able to support them-  
17 selves and obtain the course; I wonder if you could make  
18 that available to the Commission?

19 ~~the Commission~~ DR. MERRITT: The Nova Scotia Dental Associa-  
20 tion will be glad to undertake a study to find that infor-  
21 mation out. It really would be more appropriately  
22 available from the Dalhousie faculty.

23 ~~individuals~~ COMMISSIONER VAN WART: I was intending to  
24 ask Dr. Stewart today a similar question concerning the  
25 Dalhousie brief, but unfortunately Dr. Stewart is not  
26 here. If you could convey that for me to Dr. Stewart,  
27 and ask him to do the same thing for the medical students  
28 as the dental students, I would greatly appreciate it.

29 DR. MERRITT: Yes. One point about that,  
30 if I may speak in amplification of it: I believe it was



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1 stated here yesterday that the average medical dental  
2 student came from a family whose income was in a certain  
3 bracket. There are many people in this area whose incomes  
4 do not fall in that bracket who have children who are  
5 intellectually competent and sufficiently dexterous in  
6 order to take dental education.

7 COMMISSIONER STRACHAN: Mr. Chairman, I  
8 would like to refer Dr. Merritt to page 12, paragraph 35.  
9 There is no explanation given to this paragraph, and I  
10 wonder if you could inform us what number or what percen-  
11 tage this statement - and that is all it is - applies to  
12 Nova Scotia dentists; that is, where they have in their  
13 offices all of these?

14 DR. MERRITT: Sir, this is the last sentence  
15 --no, pardon me: this should follow the previous para-  
16 graph, paragraph j.: "The soundest method of determining  
17 fees is one based on the value of the service to the  
18 patient, the time required to perform the service, and  
19 the overhead cost of maintaining a dental establishment."  
20 I believe these figures are important in determining the  
21 overhead cost of maintaining a dental establishment.

22 COMMISSIONER STRACHAN: If they are used by  
23 individual dentists.

24 DR. MERRITT: If and when they are used by  
25 individual dentists.

26 COMMISSIONER STRACHAN: But this would  
27 almost lead one to believe that the greater percentage of  
28 them had all this in their offices.

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3 members of the Commission. I realized it was not true,  
4 but I would not want them to feel that.

5 DR. MERRITT: No sir, but if we are to  
6 supply more care to more people, the only way it can be  
7 done is by increasing the productivity and efficiency of  
8 each dental office, and this would require the use of  
9 more dental facilities.

10 COMMISSIONER STRACHAN: But they are not --

11 DR. MERRITT: They are not presently  
12 employed.

13 COMMISSIONER GIRARD: Dr. Merritt, looking  
14 at the auxiliary personnel of the dental profession, you  
15 have mentioned dental nurse and dental hygienist: what are  
16 the qualifications that you require of a dental nurse?

17 DR. MERRITT: There are four categories,  
18 three of which are usually considered to be female. The  
19 first is a dental assistant or receptionist who frequently  
20 has business qualifications -- a high school student or  
21 an older person, perhaps. The dental nurse is a person  
22 who has Grade 12 qualifications followed by one year of  
23 University. The dental hygienist is a female who has had  
24 University entrance followed by two years of University.

25 COMMISSIONER GIRARD: Then your dental nurse  
26 is not a qualified registered nurse?

27 DR. MERRITT: A dental nurse is not a quali-  
28 fied registered nurse.

29 COMMISSIONER GIRARD: I suppose you are aware  
30 in some Provinces you could not call her a nurse, because



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28 COMMISSIONER GILMAN: I suppose you are aware  
29 in some instances you could not call her a nurse, because





1 where the profession is incorporated the word "nurse" is  
2 reserved for the nurse who has been registered or who has  
3 a licence to practice. You never mean in this sense a  
4 registered nurse?

5 DR. MERRITT: It is the habit of some  
6 dentists to employ registered nurses. That is not the  
7 context in which "dental nurse" is used. It means in  
8 this brief one who has had one year of University, and I  
9 think the University of Toronto is the only place a course  
10 is available.

11 COMMISSIONER GIRARD: What difference do you  
12 make between what you call a dental nurse and a dental  
13 hygienist? Because I understand the dental hygienist is  
14 one who has some University preparation?

15 DR. MERRITT: Perhaps this is a little bit  
16 of history: dental assistants started back 40 years ago,  
17 and the University of Toronto undertook a course of  
18 training dental nurses, and this was a diploma course at  
19 University level, and the girls who successfully completed  
20 the course were given a diploma from the University of  
21 Toronto with the notation "dental nurse" and they were  
22 authorized to wear a purple band on their hats. The  
23 hygienist is a development of this which took place in the  
24 United States and was subsequently introduced at the  
25 University of Toronto. I believe they had difficulty  
26 filling all of their requirements in both courses because  
27 the prerequisites to admission were identical, and at some  
28 time they ceased the training of dental nurses and conti-  
29 nued only the training of dental hygienists. I believe  
30 there is now a move afoot to re-establish the training of



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2 reserved for the nurse who has been registered or who has  
3 a licence to practice. You never mean in this sense a

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15 and the University of Toronto undertook a course of  
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17 University level, and the girls who successfully completed  
18 the course were given a diploma from the University of  
19 Toronto with the notation "dental nurse" and they were  
20 authorized to wear a purple band on their hats. The

21 hygienist is a development of this which took place in the  
22 1920s and 1930s. At that time the dental profession was  
23 very much divided into two camps, the dental assistants  
24 and the dental nurses. The dental assistants were the ones  
25 who were doing the routine work, and the dental nurses were  
26 the ones who were doing the more advanced work. The dental  
27 nurses were given a diploma from the University of Toronto,  
28 and they were authorized to wear a purple band on their hats.  
29 I believe  
30 there is now a move afoot to re-establish the training of





1 dental nurses.

2 COMMISSIONER GIRARD: Since there is a great  
3 shortage of registered nurses or qualified nurses in  
4 Canada, and as you did mention that in some dentists'  
5 offices there are some registered nurses, do you personally  
6 feel that registered nurses are necessary in dentists'  
7 offices? Are they, in your opinion, giving the most in  
8 that situation that they could give as registered nurses?

9 DR. MERRITT: I think their services in a  
10 dental office are invaluable, and the decision as to  
11 whether they should be employed there rests with the  
12 employer. If he feels they are of use there, then that is  
13 the place for them to be used.

14 COMMISSIONER GIRARD: I am sure they could  
15 be of great assistance, and I am sure every dentist would  
16 like to have a nurse in his office ---

17 COMMISSIONER STRACHAN: I question that very  
18 much, Miss Girard. I don't think there is any desire of  
19 that sort.

20 COMMISSIONER GIRARD: Well, the point I was  
21 making was the shortage of qualified registered nurses.

22 COMMISSIONER STRACHAN: Well, I don't think  
23 the number taken up by dental offices would change your  
24 shortage one iota.

25 COMMISSIONER GIRARD: This is what I wanted  
26 to get.

27 COMMISSIONER STRACHAN: I would like to  
28 point out if a girl has graduated as a qualified dental  
29 nurse I doubt very much if you could stop her using the  
30 term "dental nurse" in any Province in Canada.





1 dental nurses.

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3 shortage of registered nurses or qualified nurses in

4 Canada, and as you did mention that in some dental

5 offices there are some registered nurses, do you personally

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21 making was the shortage of qualified registered nurses.

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23 the way taken up by dental offices would change your

24 shortage one iota.

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26 to get.

27 COMMISSIONER STRACHAN: I would like to

28

29

30



1 THE CHAIRMAN: I don't think we are going  
2 to be called upon to make any legal pronouncement.

3 COMMISSIONER BALTZAN: May I be clarified  
4 on this. I still don't get the function of a hygienist.  
5 What does a hygienist do?

6 DR. MERRITT: Sir, this is a difficult  
7 question for me to answer, because we have only recently  
8 instituted this program at Dalhousie University, so I  
9 cannot from our own local resources tell you what use will  
10 be made of these people. Generally, though, their assis-  
11 tance is in the administration of your practice, recalling  
12 your patients, making sure they get the treatment when  
13 they require it, in the area of prophylaxis, cleaning and  
14 polishing of teeth, application of inhibitive agents, and  
15 assisting in diagnosis and taking photographs and assis-  
16 ting the physician in evaluating treatment. These are the  
17 duties we ask them to do.

18 COMMISSIONER BALTZAN: I have read in the  
19 newspapers of the term that I couldn't understand. I  
20 don't see it mentioned here - denturist. What are they?

21 DR. MERRITT: I can't answer what a dentu-  
22 rist is. I don't find it in the dictionary. I don't know  
23 what they are.

24 COMMISSIONER BALTZAN: There may be some  
25 problem arising out of a function carried out by people  
26 termed "denturists" that provides certain mechanical  
27 appliances who are not qualified dentists.

28 DR. MERRITT: It would appear, sir, that  
29 the denturist is someone who has not a dental qualification  
30 and who has offered to provide dental treatment services.



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to be called upon to make any legal pronouncement.

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tion is in the administration of your practice, relating

your patients, making sure they get the treatment when

they require it, in the area of prophylaxis, cleaning and

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appliances who are not qualified dentists.

DR. WHEATLEY: It would appear, sir, that

the denturist is someone who has not a dental qualification

and who has offered to provide dental treatment services.





1 COMMISSIONER BALTZAN: May I ask you, could  
2 they be useful in the present situation throughout Canada  
3 where there is a shortage of dentists, or would they be a  
4 menace? We might have to deal with that, if we had such  
5 a thing as a denturist.

6 DR. MERRITT: Would they be useful?

7 COMMISSIONER BALTZAN: Would they be useful  
8 if we had such people?

9 DR. MERRITT: I don't know, sir. I feel  
10 that in our covering letter we have said that one of the  
11 duties of the dental profession is to guard the standards  
12 of treatment performed for the public. I feel if there was  
13 such a group of people that they or you or someone might  
14 apply to the dental profession to ensure that the interest  
15 of the public is protected.

16 COMMISSIONER BALTZAN: I take this liberty  
17 of discussing it with you because I know we are going to  
18 be faced with that problem. It is for an opinion rather  
19 than a test or quiz.

20 MR. HALL: Mr. Chairman, there is one matter  
21 in the brief that perhaps should be clarified. It is on  
22 page 5, paragraph 9. Towards the end of the paragraph  
23 reference is made to "solo practice", and then on page 17,  
24 paragraph 55, a recommendation made in regard to "group  
25 practices". Is "solo practice" as used on page 5 the oppo-  
26 site of "group practice" as used on page 17?

27 DR. MERRITT: I must confess that this term,  
28 "solo practice", is taken from the School of Dentistry,  
29 and I believe it means a dentist in an office with what he  
30 feels is an adequate number of auxiliaries providing a

COMMISSIONER BARTON: Why I ask you, could

they be useful in the present situation throughout Canada

and in the present situation throughout the world?

Answer: We might have to deal with that, if we had such

a thing as a dentist.

MR. MERRITT: Would they be useful?

COMMISSIONER BARTON: Would they be useful?

Answer: We had such people?

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duties of the dental profession is to guard the standards

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practice". Is "solo practice" as used on page 5 the same

as "group practice" as used on page 17?

DR. MERRITT: I must confess that this term,

"solo practice", is taken from the School of Dentistry,

and I believe it means a dentist in an office with what he

feels is an adequate number of auxiliaries providing a





1 service for a clientele; that is a man in solo practice.  
2 The term "group practice" may mean either where two or  
3 three or four men are each in solo practice and for convenience  
4 grouped in one physical location, one building, a  
5 dental clinic, where perhaps one man is an orthodontist,  
6 another man in some other specialty. This is a group of  
7 solo practices. Group practice may sometimes also mean  
8 where several dentists will agree to pool their incomes  
9 or gross incomes and pool certain expenditures and make  
10 drawings from the residuum. In other words, they can be  
11 grouped physically or economically.

12 MR. HALL: I think that section 55 makes it  
13 clear, the manner in which you use the term "group practices",  
14 but it is not quite clear to me, you say "It is suggested to the  
15 profession". Do you put that forward as  
16 a recommendation for the Commission to act on, or are you  
17 just saying you have considered it, on page 17, paragraph  
18 55?

19 DR. MERRITT: I am afraid we must confess to  
20 a little confusion in our ranks. This brief was done in  
21 part by sub-committees and then put together. I suppose  
22 we should have revamped this. Actually we have no business  
23 making recommendations to the profession when we are  
24 supposed to be making recommendations to the Commission.

25 MR. HALL: Can we take it as a recommendation  
26 to the Commission?

27 DR. MERRITT: If it is it would be an  
28 extremely difficult one for the Commission to implement.

29 COMMISSIONER FIRESTONE: Dr. Merritt, you  
30 have a number of proposals of what can be done to increase







1 the supply of dentists in the Province of Nova Scotia.  
2 Could we have from you perhaps and your Association a  
3 supplementary submission telling us how much money would  
4 be involved in proceeding with such a program you have in  
5 mind, the number of scholarships that would be required  
6 and the other things that you recommend which might be  
7 implemented? Could we have this from you in a subsequent  
8 submission?

9 DR. MERRITT: It is extremely difficult to  
10 make such a submission because it has to be based on a  
11 hypothesis of the need, and we have to find out the scope  
12 of the need. For instance, where would you need a public  
13 health appointment? You might need one in Truro, one in  
14 the valley, one in other places. So the first thing is to  
15 expand the public health department in order to get the  
16 need.

17 COMMISSIONER FIRESTONE: Have you got some  
18 views as to the need for more dentists in the Province of  
19 Nova Scotia? Have you any thoughts as to the desirability  
20 of encouraging young people to enter into the profession  
21 of dentistry, and if you have, if you want to offer scholar-  
22 ships you may have some idea of the number you wish to  
23 offer, and if so, how much they would be, and you multiply  
24 the number by the dollars and you would have some idea of  
25 the number required. You understand that the Commission  
26 is required to make some recommendations for the expansion  
27 of programs and how much they will cost, and unless we get  
28 some idea from the people in the field it is extremely  
29 difficult, and surely the people in the profession have  
30 some idea.



1 The object of this bill is to provide for the collection of  
2 duties on the importation of certain goods and to provide for  
3 supplementary submission to the Board of Customs and Finance  
4 of certain goods imported from foreign countries and to provide  
5 and the other things that you recommend which might be  
6 implemented? Could we have this from you in a separate  
7 submission?  
8 The answer is that it is a separate bill.  
9 It is a separate bill because it is not in the same  
10 hypothesis of the need, and we have to find out the scope  
11 of the need. For instance, where would you need a public  
12 health department? The answer is that it is not in the same  
13 the valley, one in other places. So the first thing is to  
14 expand the public health department in order to get the  
15 need.

16 COMMISSIONER FURSTON: Have you got some  
17 more to the bill? The answer is that it is a separate bill.  
18 The answer is that it is a separate bill because it is not in the same  
19 hypothesis of the need, and we have to find out the scope  
20 of the need. For instance, where would you need a public  
21 health department? The answer is that it is not in the same  
22 the valley, one in other places. So the first thing is to  
23 expand the public health department in order to get the  
24 need.





1 DR. MERRITT: Sir, we will attempt to under-  
2 take this and see what we come up with.

3 COMMISSIONER FIRESTONE: Thank you. And if  
4 I may add to it some indication of where the money is  
5 going to come from in order to bring it about.

6 If I may turn to the second point. The  
7 Minister of Health told us yesterday about the Department  
8 of Health having instituted a system of mobile dental  
9 clinics which would go around in the summer months and  
10 provide needed dental services to people in outlying areas  
11 as a very desirable part of the program. He also mentioned  
12 to the Commission that it was impossible to provide the  
13 service last summer because of the lack of dentists. Has  
14 your Association any recommendations to make how that  
15 deficiency could be remedied, and if you don't have the  
16 answer at the moment, would you be prepared to put it in a  
17 subsequent submission?

18 DR. MERRITT: The Minister of Health said  
19 that the shortage was serious but not urgent.

20 COMMISSIONER FIRESTONE: Do I take it from  
21 your answer that it is not necessary to provide dentists  
22 in outlying areas?

23 DR. MERRITT: That is not the submission of  
24 the Nova Scotia Dental Association.

25 COMMISSIONER FIRESTONE: Then what are your  
26 views?

27 DR. MERRITT: We feel that the needs are  
28 expanded, required by the public health program need be  
29 expanded, the number of dentists, and if these two bear  
30 fruit they must bear fruit in expanded treatment for the



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2. ...

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5. Minister of Health told us yesterday about the Department

6. of Health having instituted a system of mobile dental

7. clinics which would go around in the summer months and

8. provide needed dental services to people in outlying areas

9. - a very desirable part of the program. He also mentioned

10. to the Commission that it was impossible to provide the

11. service last summer because of the lack of dentists. Has

12. your Association any recommendations to make now that

13. deficiency could be remedied, and if you don't have the

14. answer at the moment, would you be prepared to put it in a

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17. that the shortage was serious but not urgent.

18. COMMISSIONER KIMBERSON: Do I take it from

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22. the Nova Scotia Dental Association.

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25. expanded, required by the public health program need for

26. expanded, the number of dentists, and all these two have

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28. ...

29. ...



1 people.

2 COMMISSIONER FIRESTONE: May I take it that  
3 in your supplementary submission you will make recommenda-  
4 tions how this will come about?

5 DR. MERRITT: We have made them in this  
6 brief, sir.

7 COMMISSIONER FIRESTONE: Can you then say  
8 how the Department can provide the services when they  
9 were unable to do it last summer?

10 DR. MERRITT: Because there are not enough  
11 people. Before you can have them you have to train them.

12 COMMISSIONER FIRESTONE: We were told it may  
13 take 20 years to train a sufficient number of dentists  
14 to bring up the number of dentists to the Canadian average.  
15 I asked the question yesterday whether something could be  
16 done to telescope this question, and I would like to ask  
17 you the same question in regard to the Dental Association  
18 of Nova Scotia, and if you haven't got the answer would  
19 you be prepared to give it in a supplementary submission?

20 DR. MERRITT: We haven't got any specific  
21 plans, but we do feel there is considerable assistance in  
22 rendering treatment to the public through auxiliary person-  
23 nel. We have reference to auxiliaries in our brief.

24 COMMISSIONER FIRESTONE: But my specific  
25 question related to the speeding up of training of doctors  
26 to reduce the period from 20 years simply because the  
27 people of Nova Scotia may wish to have the services in an  
28 earlier period than waiting 20 years. May we leave it with  
29 your judgment and the members in your Association to get  
30 views from you, because if we don't we will have to make



COMMISSIONER: Now I take it that

in your supplementary submission you will make recommendations

along how to do some things?

DR. WRIGHT: We have made them in our

COMMISSIONER: Can you then say

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to reduce the period from 30 years simply because the

people of Nova Scotia may wish to have the services in an

earlier period than waiting 30 years. May we leave it with

your judgment and the members of your Association to do

along from you, because if we don't we will have to make



1 up our minds.

2 DR. MERRITT: We will certainly try to do  
3 our best to give you our views.

4 COMMISSIONER FIRESTONE: Have you any thought  
5 of encouraging more ladies to enter the profession of  
6 dentistry?

7 DR. MERRITT: I would say not particularly;  
8 we have no plans to recruit the female population. Also,  
9 what scholarships we have are equally available to both  
10 females and males.

11 COMMISSIONER FIRESTONE: Thank you. My last  
12 question is: would you be in favour of a pre-paid system  
13 of dental services in the Province of Nova Scotia?

14 DR. MERRITT: Yes, sir.

15 COMMISSIONER FIRESTONE: And would you be  
16 also in favour of such a system if it were administered  
17 by a public authority, or would you prefer to reserve the  
18 answer to that question to a supplementary submission?

19 DR. MERRITT: I will reply to it extempora-  
20 neously now and amplify it at a later date, and these  
21 views are really my own. It really makes no difference  
22 whether the money comes from a public authority or through  
23 an insurance scheme or indirectly through the Government;  
24 the funds still must be raised from the public. I feel the  
25 only way we are going to get more dental care for more  
26 people is by increasing the productivity of the dentists  
27 at the present time, and this applies also on the other  
28 side of the line, that people have to be more productive  
29 if they are to have more care.

30 COMMISSIONER FIRESTONE: Then you are in



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whether the money comes from a public authority or through

an insurance scheme or indirectly through the Government;

the funds still must be raised from the public. I feel the

only way we are going to get more dental care for more

people is to have more people in the dental profession.

It is not enough to have a few people in the profession.

At the end of the line, that people have to be more productive

if they are to have more care.

COMMISSIONER FIRESTONE: Then you are in





1 favour of a universal scheme covering the people of Nova  
2 Scotia, and it would be acceptable to you and your asso-  
3 ciates that if these funds are raised in various ways and  
4 means from the public, administered by a public authority,  
5 this would be an efficient scheme to provide the maximum  
6 service available to everybody in the Province?

7 DR. MERRITT: I would like to answer that  
8 question in more detail.

9 SUBMISSION OF THE NOVA SCOTIA PHARMACEUTICAL SOCIETY

10 Appearances: J. Keith Lawton  
11 J. Esmonde Cooke  
12 Douglas A. Stallard  
13 A.W. Cox

14 MR. COX: Mr. Chairman, members of the  
15 Commission, I would just like at this time to file two  
16 exhibits on behalf of the Pharmaceutical Society. I  
17 believe Exhibit 9 is the submission and Exhibit 9A is the  
18 summary, and included in Exhibit 9A are the exhibits  
19 referred to therein numbered A to I.

20 Mr. J.K. Lawton will be making the submis-  
21 sion on behalf of the Society, and his qualifications are  
22 set forth on the page preceding page 1 of the summary.  
23 He has with him J. Esmonde Cooke, the Secretary-Registrar  
24 of the Society, Mr. Douglas A. Stallard, President of the  
25 Society. My name is A.W. Cox, and I am the solicitor for  
26 the Nova Scotia Pharmaceutical Society.

27 MR. STALLARD: Mr. Chairman, before submit-  
28 ting our brief to you I would like on behalf of the Nova  
29 Scotia Pharmaceutical Society to express our appreciation  
30 for the opportunity of presenting the brief to you this  
morning.



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ciates that if these funds are raised in various ways and  
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service available to everybody in the Province?

MR. MERRITT: I would like to answer that

question in more detail.

~~THE CHAIRMAN: I would like to ask you a question.~~

J. Ramonde Cook,  
Douglas A. Stalford

MR. COX: Mr. Chairman, members of the

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He has with him J. Ramonde Cook, the Secretary-Registrar  
of the Society, Mr. Douglas A. Stalford, President of the  
Society. My name is A.W. Cox, and I am the solicitor for  
the Nova Scotia Pharmaceutical Society.

Just one brief to you I would like on behalf of the Nova  
Scotia Pharmaceutical Society to express our appreciation  
for the opportunity of presenting the brief to you this



1 MR. LAWTON: Mr. Chairman, Commissioners,  
2 my name is J.K. Lawton. I am presenting this summary on  
3 behalf of the Nova Scotia Pharmaceutical Society.

4 AIMS OF SUBMISSION

5 Since of Nova The aims of this submission are:

6 first and as (a) to present information, opinions and

7 216. R.E.N.A. recommendations pertaining to Pharmacy in

8 Nova Scotia;

9 (b) to state the Society's willingness to

10 assist and co-operate with the Commission;

11 (c) to request the privilege of making a

12 further submission to the Commission; and

13 registered (d) to present the views of the Society as

14 to the areas and problems pertaining to

15 the Pharmacy in Nova Scotia which should be

16 studied by the Commission.

17 (see Appendix "E")

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1 My name is J.K. Lawton. I am presenting this summary on  
2 behalf of the Nova Scotia Pharmaceutical Society.

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5 recommendations pertaining to Pharmacy in

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11 to the areas and problems pertaining to  
12 Pharmacy in Nova Scotia which should be  
13 studied by the Commission.

14 (see Appendix "B")



PART II

DESCRIPTION OF SOCIETY & ACTIVITIES

S2 The Nova Scotia Pharmaceutical Society was founded in 1875, and incorporated by Chapter 11, of the Acts of Nova Scotia, 1876. It has continued since that time and is presently governed by the Pharmacy Act, Chapter 216, R.S.N.S., 1954 and its Regulations made thereunder.

See Appendix "A", summary of the Act

Exhibit "A", office consolidation of  
the Act

Exhibit "B", Regulations of the Society.

S3 The membership of the Society consists of 223 registered pharmaceutical chemists and 4 registered hospital pharmacists. Certified clerks are not members of the Society.

See Exhibit "C" for list of members and  
certified clerks.

S4 There are no industrial drug manufacturing establishments in Nova Scotia. Three firms operate a total of four wholesale drug outlets. There are 176 retail drug outlets and 51 hospital drug outlets in Nova Scotia. These terms are defined in Appendix "B".

S5 The Society is affiliated with the Canadian Pharmaceutical Association, Inc., and participates in and supports the following national organizations serving pharmacy and the Canadian public:

(a) Canadian Society of Hospital Pharmacists;

(b) Canadian Foundation for the Advancement of Pharmacy; and



ARTICLE 1

THE NOVA SCOTIA PHARMACEUTICAL SOCIETY

The Nova Scotia Pharmaceutical Society was

founded in 1875, and incorporated by Chapter 11, of the

Acts of Nova Scotia, 1875. It has continued since that

time and is presently governed by the Pharmacy Act, Chapter

116, R.S.N.S., 1954 and its Regulations made thereunder.

See Appendix "A", summary of the Act

Exhibit "A", office consolidation of

the Act

Exhibit "B", Regulations of the Society.

The membership of the Society consists of

the following persons: (a) Full members; (b) Life members;

(c) Honorary members; (d) Corresponding members; (e) Associates;

(f) Students; (g) Emeriti; (h) Honorary life members.

See Exhibit "C" for list of members and

their names.

There are no industrial drug manufacturing

establishments in Nova Scotia. Three firms operate a total

of four wholesale drug outlets. There are 176 retail drug

outlets and 51 hospital drug outlets in Nova Scotia. These

terms are defined in Appendix "B".

The Society is affiliated with the Canadian

Pharmaceutical Association and the International Union of Pure and Applied Chemists.

The following are the names of the members of the Society:

(a) Canadian Society of Hospital Pharmacists;

et al;

(b) Canadian Foundation for the Advancement

of Pharmacy; and





(c) Canadian Conference of Pharmaceutical  
Faculties.

S6 There are several specialized associations  
in Nova Scotia dealing with pharmaceutical affairs:

(a) Halifax Retail Druggists' Association;

(b) Hospital Pharmacists' Association; and

(c) Zone organizations of the Society.

S7 A summary of the establishment, aims and  
history of the Maritime College of Pharmacy is set out in  
Appendix "C".

S8 The Atlantic Provinces Pharmaceutical Advi-  
sory Council is an advisory body dealing with problems  
common to pharmacy in the Maritimes. Working through  
APPAC the three Maritime Societies arrived at a reciprocal  
arrangement permitting the transfer of registered personnel  
from province to province. We believe this to be the first  
step towards freedom of professional movement between  
provinces. The goal is a common examining Board for  
Canada, with licensing remaining an item of provincial  
jurisdiction.

S9 A list of the Officers, Council Members and  
Officials of the Society is contained in Appendix "D".

### PART III

#### PROVISION OF DRUGS AND PHARMACEUTICAL SERVICES

##### IN NOVA SCOTIA

S10 Pharmaceutical services and drugs are pro-  
vided to the people of Nova Scotia from the following  
sources:

(a) retail drug outlets;

(b) hospital drug outlets;

(c) Canadian Conference of Pharmaceutical

Associates.

There are several specialized associations

in Nova Scotia dealing with pharmaceutical affairs:

(a) Nova Scotia Pharmaceutical Society

(b) Hospital Pharmacists' Association; and

(c) Some organizations of the Society.

A summary of the establishment, aims and

activities of the Nova Scotia Pharmaceutical Society is set out in

Appendix "A".

The Nova Scotia Pharmaceutical Society is a

body which is concerned with the interests of the

pharmaceutical profession in the Maritime Provinces. Working through

ARPA the three Maritime Provinces arrived at a reciprocal

arrangement permitting the transfer of registered personnel

from province to province. We believe this to be the first

such arrangement in the history of the pharmaceutical profession.

It is the policy of the Society to maintain a high standard of

conduct and to ensure that the public interest is always

kept in mind.

A list of the Officers, Council Members and

Members of the Society is contained in Appendix "B".

### PART III

## PROVISION OF DRUGS AND PHARMACEUTICAL SERVICES

### IN NOVA SCOTIA

Pharmaceutical services and drugs are pro-

vided in Nova Scotia by the following:

(a) Retail drug outlets;

(b) Hospital drug outlets;





1 (c) Department of Veterans' Affairs;

2 (d) medical practitioners; and

3 (e) Canadian Armed Forces outlets.

4 S11 There are 176 retail drug outlets, covering  
5 the entire Province, as shown on Exhibit "D". In many  
6 cases the volume of prescription drug utilization would  
7 not in itself support, on an economic basis, a retail drug  
8 outlet. The "front store" must help support the dispensary.

9 S12 The employment of 20 registered pharmacists  
10 in the major hospitals of Nova Scotia assures pharmaceu-  
11 tical services to the majority of the larger hospitals.  
12 There is need, however, for more pharmacists in this field.  
13 Thirty-one general hospitals depend on retail drug outlets  
14 for their pharmaceutical services. In many cases these  
15 services are donated, or rendered for a nominal fee only  
16 by the pharmacists of the area.

17 S13 In the more remote areas, a supply of drugs  
18 is maintained by the physician for the immediate use of  
19 his patients. As more retail drug outlets are established,  
20 this practice diminishes.

21 S14 The armed forces maintain four pharmacists  
22 to supply the pharmaceutical needs of service personnel.  
23 This does not extend to dependants.

24 S15 Other methods of drug distribution, such as  
25 doctors' clinics, trade union clinics, and the utilization  
26 of hospitals have been tried. In most cases, after finding  
27 the innovations unsatisfactory, the people have returned to  
28 the regular channels of drug distribution.

29 S16 A highly successful program of supplying  
30 medication to diabetics has been instituted by the





(c) Department of Veterans' Affairs;

(d) medical practitioners; and

(e) Canadian Armed Forces outlets.

There are 170 retail drug outlets, covering

one entire Province, as shown on Exhibit "D". In many

cases, the outlets are operated by the same person or persons.

It is noted that, in the Province of Ontario, there are

outlet. The "front store" must help support the dispensary.

The employment of 20 registered pharmacists

in the major hospitals of Nova Scotia assures pharmacist

clinical services to the majority of the larger hospitals.

There is need, however, for more pharmacists in this field.

Thirty-one general hospitals depend on retail drug outlets

for their pharmaceutical services. In many cases these

services are donated, or rendered for a nominal fee only

by the pharmacists of the area.

In the more remote areas, a supply of drugs

is maintained by the physician for the immediate use of

his patients. As more retail drug outlets are established,

the need for such services will be reduced.

It is noted that, in the Province of Ontario, there are

110 retail drug outlets, and in the Province of Quebec,

there are 100 retail drug outlets.

Other methods of drug distribution, such as

hospitals, clinics, trade union outlets, and the utilization

of hospitals have been tried. In most cases, after finding

the innovations unsatisfactory, the people have returned to

the traditional method of drug distribution.

A highly successful program of supplying

medication to diabetics has been instituted by the



1 Provincial Government. This uses the normal retail drug  
2 outlets and thus ensures a quick and convenient source of  
3 supply that is economically reasonable.

4 PART IV

5 NEED FOR MORE PHARMACISTS IN

6 NOVA SCOTIA

7 S17 There is a need for more registered pharma-  
8 cists in Nova Scotia.

9 S18 The increase in drug products available, and  
10 the increased participation in voluntary and contributory  
11 medical plans indicates a great increase in drug utiliza-  
12 tion in the immediate future.

13 S19 It should be noted, with satisfaction, that  
14 under the Nova Scotia hospital insurance plan, it was  
15 found, in many hospitals where drug utilization was high,  
16 the length of patient stay was relatively short. Active  
17 treatment beds are being used to greater capacity due, in  
18 part, to the proper use of more advanced medication.

19 S20 In our hospitals there is a great need for  
20 well-qualified pharmacists specializing in the developing  
21 specialties of medicine. This need will become greater as  
22 progress continues to be made in research and applied  
23 medicine.

24 S21 The increased need for pharmaceutical  
25 services springs from three factors:

26 (a) increase in population;

27 (b) increase in medication available

28 because of development in drug therapy; and

29 (c) increase in medications used due to

30 increased availability of medical services.



1. The first factor is the increased need for pharmaceutical services arising from three factors:

(a) increase in population;

(b) increase in medication available;

(c) increase in development in drug therapy; and

(d) increase in medications used due to increased availability of medical services.

2. The second factor is the increased need for pharmaceutical services arising from three factors:

(a) increase in population;

(b) increase in medication available;

(c) increase in development in drug therapy; and

(d) increase in medications used due to increased availability of medical services.

3. The third factor is the increased need for pharmaceutical services arising from three factors:

(a) increase in population;

(b) increase in medication available;

(c) increase in development in drug therapy; and

(d) increase in medications used due to increased availability of medical services.

4. The fourth factor is the increased need for pharmaceutical services arising from three factors:

(a) increase in population;

(b) increase in medication available;

(c) increase in development in drug therapy; and

(d) increase in medications used due to increased availability of medical services.





1 S22 The shortage of trained pharmacists is appa-  
2 rent in three fields:

- 3 (a) in retail drug outlets, where it is  
4 difficult to measure, and where there is a  
5 need for an extensive research program to  
6 study the utilization and distribution of  
7 professional pharmaceutical talent;  
8 (b) in hospital drug outlets where the  
9 vigorous program of construction will aggra-  
10 vate the shortage in the immediate future;  
11 and  
12 (c) in the supply of pharmacy graduates  
13 employed as medical detail men servicing  
14 active medical dental and pharmacy practi-  
15 tioners.

16 PART V

17 METHODS OF EFFECTING IMPROVEMENTS

18 S23 The Society believes that the present method  
19 of distributing drugs and supplying pharmaceutical services  
20 in Nova Scotia is appropriate. This does not mean that  
21 improvements cannot be made. It does mean that there is  
22 no logical reason for changing the method and no alterna-  
23 tive in sight. We should build on what we have. We  
24 enjoy a good system of providing pharmaceutical services  
25 and drugs, a system that has served the people of Nova  
26 Scotia well for over three-quarters of a century. That  
27 system has proved itself adaptable to change. It is  
28 capable of absorbing further progress and of translating  
29 that into even greater service to the public.

30 S24 The existing methods of supplying drugs and



2 sent in three installments.

(a) in retail drug outlets, where it is difficult to measure, and where there is a need for an extensive research program to study the utilization and distribution of

(b) in hospital drug outlets where the

vigorous program of consultation will assess the knowledge in the immediate future.

(c) in the supply of pharmacy graduates employed as medical detail men serving active medical dental and pharmacy practice.

APPENDIX

THE UNIVERSITY OF TORONTO

20 in New Scotia is appropriate. This does not mean that  
21 no logical reason for changing the method and no effort  
22 time in sight. We should build on what we have. We  
23 should not waste in pursuing a method which is  
24 known well for over three-quarters of a century. The  
25 system has proved itself adaptable to change. It is  
26 capable of absorbing further progress and of translating  
27 that into even greater service to the public.

The existing methods of supply of drugs are



1 pharmaceutical services, through strategically located  
2 retail drug outlets, to the general public, and through  
3 hospital pharmacies to hospital patients, with some  
4 improvements in location and staffing, are entirely ade-  
5 quate to provide a high standard of service, at reasonable  
6 cost, to the community. The Society do not feel that  
7 there is need for any new, untried method of providing  
8 such service.

9 S25 The Society are of the opinion that there is  
10 now a firm basis, on which a greater service, with finan-  
11 cial help for certain categories of needy persons, can be  
12 established. With little additional cost, the present  
13 methods of distributing drugs and providing pharmaceutical  
14 services can be improved and extended to approach the  
15 ideal.

16 S26 Any extended pharmaceutical services should  
17 be built wisely on the experienced proved system we now  
18 enjoy.

19 S27 Instituting a comprehensive drug benefit  
20 program can only be accomplished satisfactorily over a  
21 considerable period of time. If unrestricted benefits  
22 were made available suddenly demand might exceed supply,  
23 and queues or even rationing might result. Adequate  
24 supplies and personnel must be on hand to meet the demand.  
25 Existing facilities and staff can most easily be expanded  
26 in a phased program to provide a complete and satisfactory  
27 service.

28 S28 Assuming that financial assistance in some  
29 form will be available to assist persons incapable of  
30 providing drugs from their own resources, it is likely





retail drug outlets, to the general public, and through

hospital pharmacies to hospital patients, with some

improvements in location and staffing, and entirely ade-

quate to provide a high standard of service, at reasonable

cost, to the community. The Society do not feel that

there is need for any new, untried method of providing

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and queues or even rationing might result. Adequate

supplies and personnel must be on hand to meet the demand.

Existing facilities and staff can most easily be expanded

in a phased program to provide a complete and satisfactory

service.

Assuming that financial assistance is given

there will be available to certain persons the benefit of

providing drugs from their own resources, it is likely



1 that many small communities would become appropriate areas  
2 for retail drug outlets. The so-called "front store"  
3 subsidizes the dispensary, and income from normal drug  
4 store sales, coupled with a fee for providing pharmaceuti-  
5 cal services for persons in need would enable pharmacists  
6 to establish in areas presently without adequate pharma-  
7 ceutical service.

8 S29 Prompt and efficient drug store service in  
9 a convenient locality is not a luxury. The urban centres  
10 now enjoy this service. It should be extended to include  
11 the rural areas as well. This would make a wider choice  
12 of medications available to physicians serving such areas.

13 S30 The true functions of physician and nurse  
14 are the practice of medicine and nursing respectively, not  
15 the compounding and dispensing of drugs, or the purchasing,  
16 storing, safeguarding and distributing of them, in any  
17 form other than that required for the immediate use of  
18 their patients. Should a comprehensive health services  
19 plan be established, the work load of the physician and  
20 his assistants will make it imperative that they be  
21 relieved of these tasks, to devote their entire efforts  
22 to fields in which they are expert.

23 S31 The Society recognizes and draws attention  
24 to the crying need for adequate surveys to determine,  
25 within the Province, the present manpower status and  
26 requirements. We urge the Commission to undertake these  
27 surveys, and we pledge our whole-hearted co-operation.



11. surveys, and we pledge our whole-hearted co-operation,  
12. requirements. We urge the Commission to undertake these  
13. within the Province, the present manpower needs and  
14. to the crying need for adequate surveys to determine,  
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10. storing, safeguarding and distributing of them, in any  
11. the compounding and dispensing of drugs, or the procuring,

14. are the practice of medicine and nursing respectively, not  
15. 180 the true functions of physician and nurse

8. 259 Prompt and efficient drug store services to

VI. continued services.

to establish in areas presently without adequate facilities.





PART VI

PHARMACY EDUCATION IN

NOVA SCOTIA

S32 Pharmacy education in Nova Scotia is presently undergoing extensive revision. In 1959 an advisory committee appointed by the Canadian Conference of Pharmaceutical Faculties and sponsored by the Canadian Foundation for the Advancement of Pharmacy visited the Maritime College of Pharmacy. Exhibit "H" is a copy of its report.

S33 The report recommended:

(a) that a four-year degree course based on senior matriculation should be introduced;

and

(c) that the training of pharmacists should be the responsibility of a recognized University.

S34 Attempts are being made to implement these recommendations. The College of Pharmacy was incorporated into Dalhousie University and a new four-year degree course based on junior matriculation was introduced.

S35 The pharmacists of Nova Scotia and New Brunswick are providing substantial financial assistance to pharmacy education, and Mr. Chairman, I believe that Prince Edward Island is also likely to be included in this. In order to implement completely the recommendations of the advisory committee additional financial resources will have to be provided.

S36 With the introduction of the new course enrolment will increase. For the 1960-61 term 51 students were enrolled in the College of Pharmacy. The figure has



REPORT  
OF THE  
COMMISSIONER OF PHARMACY  
FOR THE YEAR 1959

Pharmacy education in Nova Scotia is presently undergoing extensive revision. In 1959 an advisory committee appointed by the Canadian Conference of Pharmaceutical Faculties and sponsored by the Canadian Foundation for the Advancement of Pharmacy visited the Maritime College of Pharmacy. Exhibit "H" is a copy of its report.

The report recommended:

(a) that a four-year degree course based on senior matriculation should be introduced;

and

(c) that the training of pharmacists should be the responsibility of a recognized University.

Attempts are being made to implement these recommendations. The College of Pharmacy was incorporated in 1959 and is now a part of the University of Nova Scotia. The University is now planning to establish a School of Pharmacy and is expected to begin operations in 1961.

pharmacy education, and Mr. Chairman, I believe that Prince Edward Island is also likely to be included in this. In order to implement completely the recommendations of the advisory committee additional financial resources will have to be provided.

With the introduction of the new course enrolment will increase. For the 1960-61 term 21 students were enrolled in the College of Pharmacy. The figure has





1 risen to 78 at Dalhousie University for 1961-62.  
2 S37. The advisory committee estimated that to  
3 meet the future needs of the Maritime region the total  
4 enrolment should be 110. To accommodate this number,  
5 additional space and teaching staff are required. This  
6 means that further financial assistance should be provided.  
7 Provincial and federal agencies will have to increase  
8 their financial assistance to pharmacy education in the  
9 Maritimes, if this program is to be successful.

10 PART VII

11 COST OF HEALTH SERVICES

12 S38. The Society does not have the facilities or  
13 funds to study adequately the cost of drugs and pharmaceu-  
14 tical services in Nova Scotia. We respectfully suggest  
15 that the Commission consider this a vital research project  
16 and undertake the study with the full co-operation and  
17 assistance of the Society.

18 S39 Because we are not competent to determine  
19 what the essential health needs of the public are, we are  
20 not making specific suggestions regarding the assumption  
21 of costs of prescribed medicines and therapeutic devices  
22 by organizations, voluntary or sponsored, or by governments.

23 S40 Some people find the cost of drugs a severe  
24 burden, and we hope that the studies of this Commission  
25 will suggest some hope for these people.

26 S41 Experience has shown the provision of drugs,  
27 either as part of a free or contributory plan, to be a  
28 most expensive undertaking. If government assumes payment  
29 for such items the cost must obviously be borne by the tax-  
30 payer. The introduction of a government paid-for health





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4 enrollment should be 110. To accommodate this number.  
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Some people find the cost of drugs a severe  
burden, and we hope that the studies of this Commission  
will suggest some hope for these people.

most expensive undertaking. If government assumes a part



1 plan is followed by skyrocketing costs for the supply of  
2 drugs. This was the experience in both Great Britain and  
3 New Zealand.

4 S42 One reason for this is the operation of the  
5 "double-utilization rate", the tendency of the public to  
6 over use services which are "free". The patient visits  
7 the physician more frequently, resulting in an increase  
8 in the number of prescriptions written. The physician,  
9 aware that the patient will not face the cost unassisted,  
10 is inclined to be generous in estimating the type and  
11 quantity of medication prescribed. Under the Green Shield  
12 Plan in Ontario the yearly cost per person of prescribed  
13 medications rose from \$7.52 to \$18.56.

14 This, Mr. Chairman, was in 1959, and I  
15 should explain that since this was written, we found that  
16 the \$7.52 figure was an average for Canada, where the  
17 \$18.56 was restricted to Ontario.

18 S43 These high costs have compelled governments  
19 to restrict the services given "free" by various methods,  
20 some designed to limit the cost of the services, others to  
21 shift the burden of payment. Some restrictive measures  
22 used are:

- 23 (a) a ceiling on total expenditure;
- 24 (b) restricted capital construction;
- 25 (c) charges for certain services; and
- 26 (d) placing a larger proportion of the
- 27 burden on social security funds.

28 S44 To our knowledge, no western country provides  
29 drugs without restrictive conditions. In Great Britain a  
30 steadily increasing "deterrent fee" has been imposed. The







1 government has also:

2 (a) pleaded with the people to be reasonable  
3 in their demands;

4 (b) investigated alleged "over-prescribing"  
5 by physicians in an attempt to curb it; and

6 (c) imposed price restrictions on manufac-  
7 turers.

8 S45 Item (b) has interfered to some extent with  
9 professional independence and experiment and item (c) has  
10 discouraged research, both highly undesirable by-products.

11 S46 These measures have led to inconvenience to  
12 the British people, and more and more they are turning to  
13 private sources of supply - paying twice - once from their  
14 own pockets, and again through taxation. In 1959 the  
15 British people spent more for privately purchased pharma-  
16 ceuticals than did the National Health Services, and the  
17 government is not meeting the full demand for "free"  
18 medical services.

19 S47 It would be regrettable if any government,  
20 or any other body, advocated a plan, only to find out too  
21 late that the plan was not economically feasible.

22 PART VIII

23 AREAS OF STUDY FOR COMMISSION

24 S48 The Society respectfully suggests to the  
25 Commission these areas of study:

26 (a) health service programs in other  
27 countries which include drugs and pharma-  
28 ceutical services among their benefits;

29 (b) experience of such programs in utiliza-  
30 tion of drugs and pharmaceutical services;



(a) provided with the people to be responsible

in their demands;

or physicians in an attempt to curb it; and

(c) imposed price restrictions on manufacturers.

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Item (b) has interfered to some extent with

professional independence and expertise and item (c) has

discouraged research, both highly undesirable by-products.

These measures have led to inconvenience to

the British people, and more and more they are turning to

private sources of supply - paying twice - once from their

own pockets, and again through taxation. In 1959 the

British people spent more for privately purchased pharmaceuticals

than they did for those supplied by the National Health Service.

It is not surprising that the Government has been unable to

bring about a more equitable distribution of resources.

It would be regrettable if any government,

or any other body, advocated a plan, only to find out too

late that the plan was not economically feasible.

### AREAS OF STUDY FOR COMMISSION

The Society respectfully suggests to the

Commission these areas of study:

(a) health service programs in other

countries which include drugs and therapies

central services among their activities;

(b) experience of such programs in utilization

of drugs and pharmaceutical services.



1 and  
2 (c) proportion of total health care costs  
3 in such programs represented by drugs and  
4 pharmaceutical services.

5 S49 The Society also recommends to the Commission  
6 the following research projects:

7 (a) pharmacy manpower (including educational  
8 requirements);

9 (b) present and projected costs of drugs  
10 and pharmaceutical services in the Province;

11 (c) family and individual expenditure  
12 patterns for drugs and pharmaceutical  
13 services; and

14 (d) historical experience of health care  
15 programs in foreign countries.

16 PART IX

17 THE COMMISSION NEEDS A PHARMACY

18 CONSULTANT

19 S50/51/52 The Society is convinced that the Commission  
20 will require expert opinion dealing with the professional  
21 and technical aspects of pharmacy. This conviction has  
22 been borne out by those sections of the brief of the  
23 Government of Nova Scotia dealing with drugs and pharma-  
24 ceutical services. The Society is in complete agreement  
25 with the statement of principles on this subject presented  
26 by the C.Ph.A. in its preliminary statement and urges that  
27 a pharmacy consultant be appointed at an early date.

28

29

30





and

(c) proportion of total health care costs  
in such programs represented by drugs and

The Society also recommends to the Commission

the following research projects:

(a) pharmacy manpower (including educational

(b) present and projected costs of drugs

and pharmaceutical services in the future;

(c) family and individual expenditure

patterns for drugs and pharmaceutical

services; and

(d) historical experience of health care

# PART IX

## THE COMMISSION NEEDS A PHARMACY

### CONSTITUENT

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by the C.P.H.A. in its preliminary statement and urges the

a pharmacy consultant be appointed at an early date.



PART X

THE SOCIETY'S STATEMENT OF POLICY

RELATIVE TO HEALTH CARE

PLANS

S53 ~~and~~ This is set out in full in Appendix "H" of the submission. It is merely summarized here.

S54 ~~and~~ Health care programs should be examined in a light consistent with a sound philosophy which will assure a good standard of such care to every Canadian, yet will also safeguard the rights of the individual and all minority segments of the population.

S55 ~~and~~ Health care represents a financial hardship for some people. There is an understandable resistance to paying the costs of illness. The Society believes that neither of these is consistent with modern concepts of community social responsibility, nor with the availability of professional knowledge and ability.

S56 ~~and~~ The introduction of the Hospital Insurance Plan in Nova Scotia has removed part of the financial burden of illness from the individual, but the remaining elements of health care still present a financial problem to a portion of the population of Nova Scotia.

S57 ~~and~~ Action by Governments, Federal and Provincial could relieve some of the present problems. Such action should assure the practical availability of comprehensive health care, including pharmaceutical benefits to every Nova Scotian. We should first expand and extend existing voluntary medical insurance and prepayment plans. They should include pharmaceutical services. All who are presently ineligible to participate, or who are financially



...is not only in fact in the hands of

the administration, but is merely transferred here;

Health care programs should be examined in

a light consistent with a sound philosophy which will

assure a good standard of such care to every Canadian, yet

will also safeguard the rights of the individual and of

minority segments of the population.

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for some people. There is an understandable resistance

to paying the costs of illness. The Society believes that

neither of these is consistent with modern concepts of

community social responsibility, nor with the availability

of health care.

The introduction of the Hospital Insurance

Plan in Nova Scotia has removed part of the financial

burden of illness from the individual, but the remaining

elements of health care still present a financial problem

to a portion of the population of Nova Scotia.

Action by governments, federal and provincial

could relieve some of the present problems. Such action

should ensure the practical availability of necessary

health care, including pharmaceutical benefits for every

Nova Scotian. We should first expand and extend existing

voluntary medical insurance and management plans. They

should include pharmaceutical services. All who are

presently ineligible to participate, or who are financially





1 unable to pay, should be brought in. If subsidization by  
2 public funds is necessary, then it should be provided.

3 S58 Should research and study prove conclusively  
4 that it is not practical to provide an adequate standard  
5 of comprehensive health care in this manner, the Society  
6 is prepared to accept in principle and co-operate in the  
7 establishment and operation of an alternative government  
8 sponsored comprehensive plan which would be consistent  
9 with all recognized precepts of good health care and which  
10 would make such care available to all people of Nova Scotia.

11 S59 Such a plan must include pharmaceutical  
12 services provided by a pharmacist, in the form of pres-  
13 cribed drug services and specified therapeutic devices and  
14 NOT in the form of reimbursement.

15 S60 The Society dislikes compulsion, but realizes  
16 that the attainment of universal coverage is most desirable  
17 in the financing of any such health care program. Compul-  
18 sion disregards the rights of a minority. The degree and  
19 nature of compulsion as applied to the professional people  
20 involved must not be such as to emasculate the initiative  
21 of the professions, resulting in a lowering of the stan-  
22 dards of health care, an impairment of professional educa-  
23 tion, a stifling of research and a demoralization of indi-  
24 vidual practitioners. Voluntary measures should be encou-  
25 raged.

26 S61 Nothing, economic or otherwise, should be  
27 incompatible with the traditional high standards of pro-  
28 fessional responsibilities or interfere with the priceless  
29 relationship existing between patient, physician, pharma-  
30 cist and other members of the health professions.



unable to pay, should be brought in. If subordination by  
public funds is necessary, then it should be provided.

258 Should research and study prove conclusively

that it is not practical to provide an adequate standard

of comprehensive health care in this manner, the Society

is prepared to accept in principle and co-operate in the

establishment and operation of an alternative government

sponsored comprehensive plan which would be consistent

with all recognized processes of good health care and which

would make such care available to all people of Nova Scotia.

259 Such a plan must include pharmaceutical

services provided by a pharmacist, in the form of pres-

cribed drug services and specified therapeutic devices and

NOT in the form of reimbursement.

260 The Society dislikes compulsion, but realizes

that the only way to achieve the desired result is by

the use of compulsion in the form of legislation.

261 The Society is in favour of a system of voluntary

contribution to the cost of health care, but believes

that such a system should be based on the principle

of the professions, resulting in a lowering of the stan-

dards of health care, an impairment of professional educa-

tion, a stifling of research and a demoralization of indi-

vidual practitioners. Voluntary measures should be encour-

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262 Nothing economic or otherwise should be

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dards of health care, an impairment of professional educa-

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vidual practitioners. Voluntary measures should be encour-



1 S62 To be acceptable to the Society any compre-  
2 hensive health care plan must observe the following funda-  
3 mental principles in respect of pharmaceutical benefits:

4 (a) there must be recognition of the  
5 existing division of legislative responsi-  
6 bility concerning pharmacy and drugs, and  
7 nothing shall contravene this;

8 (b) drugs and all pharmaceutical services  
9 shall be supplied directly to the public  
10 only by pharmacists through legally autho-  
11 rized and regulated outlets; in hospitals  
12 the supplying of drugs and related profes-  
13 sional services shall be limited to bona  
14 fide hospital patients;

15 (c) pharmacy shall have direct representa-  
16 tion on any body charged with the initiation  
17 and development of policies pertaining to  
18 pharmaceutical services; pharmacists should  
19 be directly involved in administering such  
20 policies;

21 (d) the patient shall be free to obtain  
22 pharmaceutical services from the pharmacist  
23 of his choice;

24 (e) a pharmacist shall be free to conduct  
25 his practice, or any part thereof, outside  
26 such health care plan if he so chooses;





1 362

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21 pharmaceutical services from the pharmacy

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24 his practice, or any part thereof, outside

25 such health care plan if he so chooses;



1 (f) benefits shall include any and all  
2 drugs considered necessary by the physician  
3 for the welfare of the patient, as well as  
4 specified therapeutic devices; the only  
5 restrictions on prescribing should be in  
6 terms of quantity for any single prescrip-  
7 tion and the number of times it may be  
8 repeated;

9 (g) the Society does not favor deterrents  
10 but if they are necessary they should be  
11 used solely for the purpose of controlling  
12 over-utilization and NOT primarily as a  
13 source of revenue; and

14 (h) pharmacists shall have the right to  
15 determine the basis of their remuneration  
16 for professional services as distinct from  
17 payment for materials involved in rendering  
18 pharmaceutical services; the amount and  
19 manner of such remuneration shall be a  
20 matter of negotiation from time to time to  
21 reflect changes in economic conditions.

22 Mr. Chairman and Commissioners, Part XI  
23 refers to the drug nomenclature and it has been put in as  
24 having some bearing on the cost of prescribing drugs, and  
25 if you would like, I can read it.

26 THE CHAIRMAN: You go ahead as you wish.

27 MR. LAWTON: Appendix "I" deals with this  
28 in detail, and it is the brand name versus generic name  
29 controversy.



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controversy.





PART XI

DRUG NOMENCLATURE - THE "BRAND NAME"

vs. "GENERIC NAME" CONTROVERSY

S63 Appendix "I" deals with this in detail.

This is a summary.

S64 There are three types of names used for particular drugs:

(a) the "chemical name" (sometimes called the "systematic chemical name") which is descriptive of the chemical composition of the drug;

(b) the "generic name" (in reality a misnomer as far as drugs are concerned; more accurately it should be the "non-proprietary name") which is the common name of the drug which becomes settled when the drug is listed in one of the official reference books on drugs; and

(c) the "trade or brand name" (more accurately the "proprietary name") under which a supplier will sell the drug under a registered trade name.

S65 The use of a brand name in itself is no guarantee of quality. See Dr. Morrell, Toronto Globe and Mail, 18 August, 1960:

"When it comes to buying top quality drugs the things to check are the ability, facilities, personnel and conscience of the drug manufacturer....

"Neither a brand name nor a drug's generic



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times the "proprietary name") under which

a supplier will sell the drug under a

registered trade name.

The use of a brand name in itself is no

guarantee of quality. See Dr. Martell, Toronto Globe and

Mail, 10 August, 1963.

When it comes to buying top quality drugs

the things to look for are quality, purity,

and, personal and knowledge of the drug

manufacturer.

Neither a brand name nor a generic name



1 name is the sole reliable guide to quality...

2 "The real point is who makes the drug and

3 how it's made - the control system that

4 insures careful and scientific testing for

5 potency and stability".

6 S66 Reference is suggested to Appendix "I" and

7 particularly to those portions taken from the article by

8 Dr. Lloyd C. Miller in the Journal of The American Medical

9 Association of 8 July, 1961 at p. 27 and following.

10 S67 Much can be achieved in this field by co-ope-

11 ration. Many desirable results would flow from the adoption

12 by the Food and Drug administration of a policy requiring,

13 as a matter of safety, that the labelling of all new drugs

14 subject to new drug applications should employ the name

15 used in the official reference books, if there is one, or

16 find out what "common or usual name" has been established,

17 and require that it be used. Generic, or non-proprietary,

18 names should be as short and pronounceable as possible,

19 even although brevity is difficult to achieve.

20 S68 There should be some administrative body

21 vested with effective authority (1) to require the

22 selection and use of a generic or non-proprietary name

23 for every drug entity, and (2) to prohibit the selection

24 and use of more than one name for any single compound.

25 There should be more uniformity in the manner in which

26 individual pharmaceutical firms go about naming their pro-

27 ducts. Such firms should agree to select such names in

28 co-operation with an effective central authority for all

29 new drugs before their introduction on the market, prefe-

30 rably at the time when the new drug application is made.





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1 S69 This controversy was aired at the Halifax  
2 hearings of the Restrictive Trade Practices Commission  
3 relating to the manufacture, distribution and sale of  
4 drugs. The Society's presentation to that Commission is  
5 submitted as Exhibit "G".

6 S70 Dr. C.H. Reardon and Dr. J.W. Reid gave  
7 evidence before the Commission, and attention is directed  
8 to their evidence as set out in Appendix "I".

9 S71 Attention is also directed to the Interim  
10 Report on a Study of Pharmacy in Saskatchewan set out in  
11 Appendix "I" at pp. I 15 and I 16.

12 S72 Pharmacists find themselves in a peculiar  
13 and unenviable position, not of their own making, in  
14 this controversy. The general public - and especially its  
15 vocal, though sometimes ill-informed self-appointed spokes-  
16 men - reluctant to pay drug costs, seizes on a deceptively  
17 simple solution to the cost problem - let all prescribing  
18 be by "generic name".

19 S73 There are three factors involved in supplying  
20 drugs to the public, the manufacturer, the prescribing  
21 doctor and the dispensing pharmacist. The pharmacist has  
22 no control over the other two. The manufacturer largely  
23 determines the cost. The physician orders the drug to be  
24 dispensed. The pharmacist must supply "what the Doctor  
25 orders" in the strictly literal sense. The choice of  
26 prescribing by "brand" or "generic" name is that of the  
27 physician. If the physician prescribes by brand name the  
28 pharmacist must dispense the requested brand. Only if  
29 the physicians prescribe generically can the pharmacist  
30 dispense one of several "brands" of the generic drug



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11 Appendix "I" at pp. 13 and 14.  
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13 and unstable position, not of their own making, in  
14 this controversy. The general public - and especially its  
15 vocal, though sometimes ill-informed self-appointed spokes-  
16 men - reluctant to pay drug costs, raises on a deceptively  
17 simple solution to the cost problem - let all prescribing  
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1 prescribed.

2 S74 Confidence in drugs is largely a matter of  
3 believing in the quality and quantity controls maintained  
4 by the manufacturer.

5 S75 It may be that a wider use of "generic"  
6 names by physicians will effect certain cost savings.  
7 But under no circumstances should such savings be made at  
8 the expense of quality.

9 S76 The Society respectfully recommends that  
10 the Commission make a thorough study of this problem to  
11 determine if it is feasible to simplify the present system  
12 of drug nomenclature and prescribing procedures, and thus  
13 effect cost savings.

14 PART XII

15 CONCLUSION

16 S77 Finally, we would like to draw attention to  
17 a paragraph contained in the "Final Report of the Committee  
18 on the Cost of Prescribing" chaired by Sir Henry Hinch-  
19 cliffe. The paragraph referred to is contained in the  
20 financial statement and summary of the report and reads  
21 as follows:

22 "There is no satisfactory alternative to  
23 the present system of supplying National  
24 Health Services medicines through the  
25 established retail channels. If purchase  
26 and distribution of medicines were under-  
27 taken centrally or through health centres,  
28 costs would increase".

29 S78 All of which is respectfully submitted.

30



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1  
2 --- EXHIBIT NO. 9: Brief of Nova Scotia Pharmaceutical  
3 Society.

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5 --- EXHIBIT NO. 9A::Summary of submission.  
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--- EXHIBIT NO. 9: Brief of Nova Scotia Pharmaceutical Society.

EXHIBIT NO. 10: Summary of Proceedings

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SUBMISSION OF  
NOVA SCOTIA PHARMACEUTICAL SOCIETY

INTRODUCTION:

1. This submission is respectfully made to the Royal Commission on Health Services by the Nova Scotia Pharmaceutical Society. This Society was founded by 1875 and incorporated by Chapter 11, of the Acts of the Legislature of Nova Scotia, passed in the year 1876. The preamble to that Act read as follows:

"Whereas it is expedient for the safety of the public, that all persons engaged in the sale or dispensing of drugs and medicines within this Province should be acquainted with their properties and uses, and possess a competent practical knowledge of pharmacy; and that provision be made for testing the knowledge and capability of all persons hereunder proposing to engage in the afore-said business:

"Be it therefore enacted by the Governor, Council and Assembly as follows:"

The Society created by that Act has continued and is presently governed by Chapter 216, Revised Statutes of Nova Scotia, 1954 as amended by Chapter 37 of the Acts of 1957. The Society has had the revision of this legislation under intensive review for the past three years, and a new draft Act has been prepared in preliminary form. This was given tentative approval by the Society at its 1961 annual meeting.



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2. A summary of the provisions of the Pharmacy Act is attached to this submission as Appendix "A" and an office consolidation of the Act is submitted as Exhibit "A". The regulations are Exhibit "B".

3. Certain terms are defined in Appendix "B". These definitions are necessary for clarity as the Pharmacy Act creates three classes of "pharmacists" in Nova Scotia, a situation which we believe to be unique in Canada. If a new Act is submitted to the Legislature for approval, it will probably abandon this division of the profession and return to one classification of registered pharmacist.

4. The membership of the Society consists of:

(a) 223 registered pharmaceutical chemists;

and

(b) 4 registered hospital pharmacists.

There are no registered wholesale pharmacists. These figures are as of the 1st day of June, 1961. The Society also has 3 honorary members, but these members cannot practice pharmacy on the strength of this membership. There are also approximately 20 associate members who are not actively engaged in the practice of pharmacy. In addition "observer privileges" are extended from time to time to visiting pharmacists, but this does not carry with it the privilege of practicing pharmacy in Nova Scotia.

Students enrolled with the College of Pharmacy at Dalhousie University number 78. Certified clerks are registered under the Act, but are not members of the Society. Exhibit "C" is a list of registered members and certified clerks.

5. There are no drug manufacturing establishments in Nova Scotia. Three firms carry on business as whole-

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1 salers of drugs, and they operate four wholesale drug  
2 outlets. There are 176 retail drug outlets and 51 hospital  
3 drug outlets in Nova Scotia.

4 6. The Society is affiliated with other  
5 provincial pharmaceutical associations in the Canadian  
6 Pharmaceutical Association, Inc. There are several  
7 specialized associations within Nova Scotia:

8 (a) The Halifax Retail Druggists Associa-  
9 tion, which is an unincorporated association  
10 of pharmacists operating retail drug outlets  
11 in the Halifax area. The great majority of  
12 members in the Halifax area support the  
13 Association.

14 (b) The Hospital Pharmacists Association,  
15 which is an unincorporated association of  
16 pharmacists engaged in hospital drug outlets  
17 in Nova Scotia. This is a division of the  
18 Canadian Society of Hospital Pharmacists,  
19 and has approximately 20 members.

20 (c) The Society is unofficially organized  
21 into a number of Zones on a geographical  
22 basis in the province. These zones hold  
23 meetings and deal with purely local problems  
24 effecting the practice of pharmacy in their  
25 particular areas.

26 7. Members of the Society participate actively  
27 in the following national organizations serving pharmacy  
28 and the Canadian public:

- 29 (a) Canadian Pharmaceutical Association,  
30 (b) Canadian Society of Hospital Pharmacists,





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7. Members of the Society participate actively in the following national organizations serving pharmacy and the Canadian public:

(a) Canadian Pharmaceutical Association



(c) Canadian Foundation for the Advancement  
of Pharmacy, and

(d) Canadian Conference of Pharmaceutical  
Faculties.

8. The other A brief summary of the establishment aims  
and history of the Maritime College of Pharmacy is attached  
as Appendix "C".

9. The Society participates in the Atlantic  
Provinces pharmaceutical Advisory Council (APPAC). As  
its name indicates, the Council is an advisory body com-  
posed of the President, Registrar and one other member  
from each of the Pharmaceutical Societies and Associations  
of the Maritime Provinces. The Dean of the Maritime College  
of Pharmacy is also a member of Council. The Council  
provides a clearing house where topics of common interest  
to pharmacists of the Maritime area may be aired and  
recommendations of an advisory nature made to the res-  
pective provincial bodies in matters for the betterment  
of pharmacy and the service rendered by pharmacists to  
the public. Working through APPAC the three Maritime  
Pharmaceutical Societies arrived at a reciprocal arrange-  
ment permitting the transfer of registered pharmacists  
from province to province. This is the first step of  
which we are aware in Canada towards freedom of prof-  
essional movement between provinces. The goal is a  
common examining board for Canada with licensing remaining  
an item of provincial jurisdiction.

10. A list of the Officers, Council Members and  
Officials of the Society is attached as Appendix "D".



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10. A list of the Officers, Council Members and

of the Society is attached as Appendix "D".





1 COMMISSIONER BALTZAN: Mr. Chairman, I have  
2 nothing but commendation for what is said here. Mr.  
3 Lawton, I know you have confined yourself to a strict  
4 form of business, but some of us are also looking to some  
5 of the other things that increase the cost of treatment  
6 to patients, and whether it comes under your aegis or not,  
7 who pays attention to it, or where we can get some informa-  
8 tion on the amount of money that people spend on what you  
9 term proprietary drugs, but it means across-the-counter  
10 drugs by self-prescription: I understand that is a very  
11 costly business, and increases the budget extensively,  
12 and I am not prepared to say how much they get out of it,  
13 but is there a source area where we can obtain that infor-  
14 mation?

15 MR. LAWTON: I doubt very much whether the  
16 information is readily available. I would think possibly  
17 some part of that information could be obtained from the  
18 manufacturers' associations and proprietary drug manufac-  
19 turers' associations. Apart from that I don't know,  
20 because most drugstores in the Province are so small they  
21 would not have a breakdown. I think some research could  
22 be done on it, but I believe the only true answer could  
23 be had from the people who distribute these products.

24 COMMISSIONER BALTZAN: Am I correct in  
25 accepting the statement that there is a lot of money  
26 spent, for instance, in indiscriminatory swallowing of a  
27 lot of vitamin pills that people think they are short of?

28 MR. LAWTON: I would think you would be  
29 right, sir, yes; the very high pressure advertising of  
30 some vitamin companies, and mail order type of thing, such



COMMISSIONER BARTMAN: Mr. Chairman, I have

nothing but commendation for what is said here. Mr.

Lawson, I know you have confined yourself to a strict

form of business, but some of us are also looking to some

of the other things that increase the cost of treatment

to patients, and whether it comes under youregis or not,

who pays attention to it, or where we can get some informa-

tion on the amount of money that people spend on what you

term proprietary drugs, but it means across-the-counter

drugs, and I think that is a very important question.

And I think that is a very important question.

And I think that is a very important question.

It is a source area where we can obtain that infor-

mation.

MR. LAWSON: I doubt very much whether the

information is available. I think it is a very

important question, and I think it is a very

important question, and I think it is a very

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1 as the Book of the Month Club idea where you get them  
2 automatically whether you want them or not after you send  
3 in for the original sample. That type of thing is not  
4 good, and there is no control over the use of vitamins  
5 at all at that stage.

6 THE CHAIRMAN: Mr. Lawton, on page 8, S31,  
7 you read that the Society recognizes and draws attention  
8 to the crying need for adequate surveys to determine  
9 within the Province the present manpower status and require-  
10 ments. You urge the Commission to undertake those surveys.  
11 Is there any good reason why the Nova Scotia Society  
12 should not undertake such a survey -- and I don't put that  
13 facetiously, because, as you see, if you were here yester-  
14 day, the Canadian Medical Association filed material  
15 covering a manpower survey, and the Commission is going  
16 to be making independent studies of its own, but we would  
17 like to have the Society's estimate of its own requirements.

18 MR. LAWTON: Yes, Mr. Chairman. In this  
19 connection we understand that the Canadian Pharmaceutical  
20 Association has requested the Commission to undertake the  
21 survey through its own research facilities. We felt when  
22 our committee studied this that we were only a small  
23 group -- we have about 220 members -- and we didn't have  
24 the time or facilities or any special competence to do  
25 this type of survey, and assumed, rightly or wrongly, that  
26 one of the things the Commission would be interested in  
27 doing would be this type of survey. I think if such a  
28 survey was ever undertaken you would certainly have the  
29 wholehearted co-operation of all the pharmacists in making  
30 this information available.





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to be making independent studies of its own, but we would

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THE CHAIRMAN: Yes, Mr. Lawton.

In connection we understand that the Canadian Pharmaceutical

Association has requested the Commission to undertake the

survey through its own research facilities. We felt when

our committee studied this that we were only a small

group -- we have about 200 members -- and we didn't have

the time or facilities or any special competence to do

this type of survey, and assumed, rightly or wrongly, that

one of the things the Commission would be interested in

doing would be this type of survey. I think if such a

survey was ever undertaken you would certainly have the

co-ordinated co-operation of all the pharmacists in making

this information available.



1 THE CHAIRMAN: You go on to page 9 and you  
2 say the advisory committee estimated that to meet the  
3 future needs of the Maritime region total enrolment should  
4 be 110.

5 MR. LAWTON: Yes.

6 THE CHAIRMAN: How do you pick on 110 without  
7 an antecedent survey?

8 MR. LAWTON: Well, the Commission that did  
9 this study, Mr. Chairman, based their estimate here on  
10 the ratio of pharmacists to population in other areas of  
11 Canada, and based on that study they felt the College  
12 should have an enrolment of 110 to turn out sufficient  
13 pharmacists to bring it up to the Canadian average. That  
14 survey, Mr. Chairman, is the one referred to in Exhibit  
15 "H".

16 THE CHAIRMAN: There was a figure given on  
17 page 10, and you made a correction: you state under the  
18 Green Shield Plan for Ontario the yearly cost per person  
19 for prescribed medicines rose from \$7.50 to \$18.56,  
20 which is a very pronounced increase. Have you got the  
21 figure for Ontario which would show the rise in Ontario?

22 MR. LAWTON: No, sir. This came just late  
23 last night, and one thing we were able to find was that  
24 the Dominion Bureau of Statistics city family expenditure  
25 for the year 1959 in Ontario was \$9; for all of Canada it  
26 was \$7.52. There are two different surveys.

27 THE CHAIRMAN: Where did you get the \$18.56  
28 figure?

29 MR. LAWTON: That came from a Green Shield  
30 Plan operated by Prescription Services Incorporated in



THE CHAIRMAN: You go on to page 2 and you

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THE CHAIRMAN: Where did you get the \$18.50

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1 Windsor, Ontario. They have the pilot plan in operation  
2 there for a number of years.

3 THE CHAIRMAN: But it is not an overall  
4 plan for the Province? It is a small area in Ontario?

5 MR. LAWTON: It is in a small area; it is  
6 only in the Windsor area, but other drugstores in other  
7 communities -- for instance, Hamilton -- some pharmacists  
8 there participate in this Green Shield Plan.

9 THE CHAIRMAN: Again you say at page 10  
10 that the introduction of a Government paid-for health  
11 plan was followed by skyrocketing costs for the supply of  
12 drugs, and this was the experience both in Great Britain  
13 and New Zealand. Have you got the figures to support the  
14 statement?

15 MR. LAWTON: Yes, sir, we have, on page 19  
16 of the brief. Mr. T.M. Ross, in an article entitled An  
17 Analysis of Prepayment of Prescriptions under the Green  
18 Shield Plan pointed out some costs here. Again I must  
19 admit we looked for the actual figures -- we have heard  
20 but we could not substantiate them, that the estimates  
21 in England for the first year of the plan could be  
22 60 million pounds on drugs, and I think it went conside-  
23 rably higher than that and eventually went up, in 1959,  
24 to 240 million pounds. Again I am not able to substantiate  
25 this at the present time.

26 THE CHAIRMAN: Have you got the comparative  
27 figure for the costs of drugs in any given year in  
28 England as compared with the costs of medical services?

29 MR. LAWTON: No sir, I am sorry I haven't.

30 COMMISSIONER FIRESTONE: Mr. Lawton, you



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figures for the costs of drugs in any given year in

England as compared with the costs of medical services?

MR. LAWTON: No sir, I am sorry I haven't.

COMMISSIONER FOR THE HOUSE OF COMMONS: Mr. Dawson, you





1 have made some proposals in your submission with respect  
2 to the necessity of training additional pharmacists: could  
3 you spell out, not necessarily in answer to my question  
4 but in the form of a subsequent submission, how much this  
5 would cost and what kind of scholarships or fellowships  
6 you have in mind for the Province of Nova Scotia; how  
7 much per student and how many? Would you prefer to give  
8 us the answer subsequently, or do you want to answer it  
9 now?

10 MR. LAWTON: It would be preferable to do  
11 it subsequently, sir.

12 COMMISSIONER FIRESTONE: Well, could you  
13 go through your whole brief and include in your subsequent  
14 submission the financial implications of all proposals  
15 you have made for improving pharmaceutical service and  
16 where the money is going to come from to pay for them?

17 MR. LAWTON: I am not sure we are competent  
18 to do it, but we will make an effort to do it.

19 COMMISSIONER FIRESTONE: You will give us  
20 your views?

21 MR. LAWTON: Yes, sir.

22 COMMISSIONER FIRESTONE: Thank you. Is your  
23 Nova Scotia Pharmaceutical Society in favour of a prepaid  
24 scheme for the provision of drugs to those requiring drugs  
25 for medical purposes, or would you prefer to answer the  
26 question also in a subsequent submission?

27 MR. LAWTON: I think we can answer that one  
28 here. We are in favour of a prepaid scheme to provide  
29 drugs for people who need assistance. We are in a free  
30 enterprise system, and we are concerned about taxation and



to the necessity of training additional pharmacists; could

you spell out, not necessarily in answer to my question

but in the form of a subsequent submission, how much this

would cost and what kind of scholarships or fellowships

you have in mind for the Province of Nova Scotia; how

much per student and how many? Would you prefer to give

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scheme for the provision of drugs to those requiring drugs

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question also in a subsequent submission?

MR. LAWTON: I think we can answer that one

now. We are in favour of a prepaid scheme to provide

drugs for people who need assistance. We are in a firm

position on this system, and we are prepared to submit a



1 this type of thing, and we feel anybody who has the  
2 resources to look after his own bills should be able to  
3 do it. We strongly advocate the people who are not able  
4 to do this should be given some form of assistance.

5 THE CHAIRMAN: How would you find out that  
6 class? How would you determine that class?

7 MR. LAWTON: I think we would have to fall  
8 back on means test, possibly through income tax returns  
9 or something of that nature.

10 COMMISSIONER FIRESTONE: Thank you, Mr.  
11 Chairman; that was very helpful. If I may follow that  
12 questioning a little further, you are in favour of arrange-  
13 ments which would provide for the payment of drugs for  
14 those who cannot pay for them themselves, and that this  
15 will be a tax-supported scheme?

16 MR. LAWTON: I would think so, yes. I  
17 can't see any other way to get the funds for this.

18 COMMISSIONER FIRESTONE: The answer to that,  
19 then, is "yes". Can we talk about the other group that  
20 are in a position to pay for such drugs: would you be in  
21 favour of a prepaid scheme for those people so that the  
22 risks involved of paying for drugs are spread over a  
23 large number of people rather than on the people that  
24 need drugs -- and some of them are very expensive, as you  
25 know, when you are seriously ill? Would you be in favour  
26 of a prepaid scheme for those that can afford to pay for  
27 drugs?

28 MR. LAWTON: On a voluntary basis, yes sir.

29 COMMISSIONER FIRESTONE: You would be in  
30 favour of a scheme on a voluntary basis. Would you be in

this type of thing, and we feel anybody who has the  
resources to look after his own bills should be able to  
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large number of people rather than on the people that

need drugs -- and some of them are very expensive, as you

know, when you are seriously ill? Would you be in favour

of a prepaid scheme for those that can afford to pay for

MR. LAWTON: On a voluntary basis, yes sir.

COMMISSIONER FIRSTONE: You would be in

favour of a scheme on a voluntary basis. Would you be in





1 favour of such a scheme on a voluntary basis if that scheme  
2 were administered by a Government authority?

3 MR. LAWTON: I believe we have set out that  
4 if it is absolutely necessary that the Government become  
5 involved in this that we will co-operate in it, but again  
6 we emphasize we would prefer to deal with private compa-  
7 nies or prepayment groups such as Maritime Medical Care.

8 COMMISSIONER FIRESTONE: Can you explain to  
9 us the reasons for your preference?

10 MR. LAWTON: There again, we are free enter-  
11 prisers, and we feel it is better to deal with companies  
12 such as this rather than dealing with Governments.

13 COMMISSIONER FIRESTONE: Thank you very  
14 much.

15 THE CHAIRMAN: Thank you very much, gentle-  
16 men. We will now adjourn until 2 o'clock when we will  
17 proceed with the submission from the Victorian Order of  
18 Nurses.

19  
20 --- Luncheon adjournment.

21

22

23

24

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30



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2 were administered by a Government authority?

3 MR. LEWTON: I believe we have set out that

4 if it is absolutely necessary that the Government become

5 involved in this that we will co-operate in it, but again

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7 nies or payment groups such as Maritime Medical Care.

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13 COMMISSIONER FIRESTONE: Thank you very

14 much.

15 THE CHAIRMAN: Thank you very much, gentle-

16 men. We will now adjourn until 2 o'clock when we will

17 proceed with the continuation from the Victorian Order of

18 Nurses.

19  
20 --- Luncheon adjournment.



1 --- On resuming at 2 p.m.

2 SUBMISSION OF THE VICTORIAN ORDER OF NURSES

3 FOR CANADA

4 Appearances: Mrs. George Reid, Provincial President  
5 for Nova Scotia  
6 Miss Jean Leask, Director-in-Chief of  
7 Canada

8 MRS. REID: Mr. Chairman, members of the  
9 Commission, it is my pleasure and privilege to introduce  
10 Miss Jean Leask. I am speaking as a representative of the  
11 Board of Governors for the Victorian Order of Nurses for  
12 Canada and as President for Canada.

13 Miss Leask will now present the summary of  
14 the short preliminary brief.

15 MISS LEASK: Mr. Chairman, members of the  
16 Commission, The Victorian Order of Nurses for Canada is a  
17 national, voluntary, public health nursing organization  
18 with headquarters in Ottawa. Branches have been established  
19 in all provinces with the exception of Prince Edward Island.  
20 These branches are located in 118 cities, towns and coun-  
21 ties across Canada. More than 650 nurses are employed by  
22 the Order.

23 The purpose of this preliminary statement is  
24 to provide background material relating to the origin and  
25 development of the Victorian Order, its objectives and  
26 administration as well as the general policies under which  
27 service is given in all branches. This information is  
28 presented to assist the members of the Commission in their  
29 consideration of further provincial and national submissions.

30 B. SUMMARY

1. With the founding of the Victorian Order



On resuming at 2 p.m.

THE CANADA

Present: Mrs. George Reid, Provincial President  
Mrs. Nova Scott  
Miss Jean Leask, Director-in-Chief of

Mrs. Reid, Mr. Chairman, members of the

Commission, it is my pleasure and privilege to introduce

Miss Jean Leask. I am speaking as a representative of the

Board of Governors for the Victorian Order of Nurses for

Canada and as President for Canada.

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29 E. SUMMARY

With the founding of the Victorian Order



1 of Nurses in 1897, visiting nursing was introduced into  
2 Canada. For over 60 years the organization has given  
3 leadership in the growth and development of this service.  
4 Through its flexible policies and program and its early  
5 association with the modern public health movement, the  
6 Order has contributed to the development of other public  
7 health nursing services in many communities. The original  
8 charter of the Order was replaced by an Act of Parliament  
9 of Canada which became effective in 1954 and under which  
10 the Victorian Order of Nurses for Canada is incorporated.  
11 The present objectives are stated in this Act and are  
12 included in this submission. Throughout the years the  
13 objectives have indicated the Order's concern, not only  
14 with the care of the sick, but also with the prevention of  
15 illness and the promotion of health. They have reflected  
16 the organization's responsibility for developing and exten-  
17 ding service, for maintaining the quality of nursing care  
18 given, and for assisting in the training of personnel.

19 2. From its beginning, the Victorian Order  
20 has sought to plan and adapt its program to the needs of  
21 a community. This has resulted in a variety of services  
22 being offered not only from branch to branch but from  
23 province to province. The program in any area is planned  
24 in consultation with local and provincial health authori-  
25 ties and is carried on in co-operation with hospitals and  
26 other health and social agencies, both official and volun-  
27 tary. All branches of the Victorian Order accept the  
28 basic policies of the national organization relating to the  
29 care of patients.

30 The primary function of the Order is to



Canada. For over 60 years the organization has given leadership in the growth and development of this service. Through its flexible policies and program and its early association with the modern public health movement, the Order has contributed to the development of other public health nursing services to many communities. The original charter of the Order was replaced by an Act of Parliament of Canada which became effective in 1954 and under which the Victorian Order of Nurses for Canada is incorporated. The present objectives are stated in this Act and are included in this submission. Throughout the years the objectives have indicated the Order's concern, not only with the care of the sick, but also with the prevention of illness and the promotion of health. They have reflected the organization's responsibility for developing and extending services, for maintaining the quality of nursing care given, and for assisting in the training of personnel.

2. From its beginning, the Victorian Order has been a community. This has resulted in a variety of services being offered not only from branch to branch but from the central office to the community. The Order has been successful in its efforts to coordinate with local and provincial health authorities in the development of health services. The Order has been successful in its efforts to coordinate with local and provincial health authorities in the development of health services. The Order has been successful in its efforts to coordinate with local and provincial health authorities in the development of health services.





1 provide skilled nursing care to patients in their homes on  
2 a visit basis and to combine with this care, health teaching  
3 to the patient and family. This care is available in all  
4 branches to anyone in the community regardless of age, sex,  
5 creed or financial status. It is available on a 24-hour  
6 basis for all types of illness, acute, chronic or convales-  
7 cent and to mothers and babies. Other services are  
8 offered in many branches. These activities are undertaken  
9 to fill a need for service which is not being offered by  
10 another agency, to contribute to a more comprehensive  
11 service in a community through sharing a program with  
12 another agency, or to initiate or demonstrate a service  
13 which should be developed. Student field experience or  
14 observation is provided for nursing and medical students.

15 3. Policies and standards are set at the  
16 national level and are accepted by all branches. The  
17 conduct of the affairs of the Order is the responsibility  
18 of a national board of governors and of boards of manage-  
19 ment and committees at the national, provincial and local  
20 level. This voluntary citizenship participation is a  
21 fundamental principle of the organization. The administra-  
22 tion, supervision and development of the nursing service  
23 is the responsibility of the nursing staff of the Order.  
24 The structure of the organization provides for liaison  
25 between the national, provincial and local levels.

26 4. To maintain and improve the quality of  
27 nursing care provided, standards regarding the qualifica-  
28 tions and employment of staff have been established. For  
29 staff positions, preparation in public health nursing is  
30 desired and, in employment, preference is given to nurses

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28 4. To maintain and improve the quality of  
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32 desired and, in employment, preference is given to nurses





1 with this qualification. For administrative and super-  
2 visory positions, preparation in administration and super-  
3 vision in public health nursing is desired and, for senior  
4 positions, is required. All nurses are registered in the  
5 province in which they are employed. A small group of  
6 nursing assistants is employed in three of the large  
7 branches of the Order.

8 To assist nurses to obtain public health  
9 nursing qualifications, bursaries are offered each year  
10 by the national organization. In-service education  
11 programs, library facilities and attendance at refresher  
12 courses assist staff in maintaining the quality of service.

13 A guide for personnel policies has been drawn  
14 up by the national organization to provide a basis on which  
15 personnel policies in the branches may be established. A  
16 pension plan for all employees, nursing or clerical, is  
17 administered by the national office.

18 5. The boards of management at the national,  
19 provincial and local level are responsible for securing  
20 the necessary funds to carry on Victorian Order programs.  
21 Each branch is responsible for financing the service in  
22 its area. The average cost for Victorian Order service in  
23 each branch is computed annually on a visit basis. The same  
24 costing system is used by all branches. Because of the type  
25 of area served, the size, location and the type and amount  
26 of service given, costs vary from branch to branch.

27 6. Statistical information from the service  
28 records of the Victorian Order is available from two  
29 sources. One method produces information relating to the  
30 current volume of service given. The other method secures





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29 records. The method produces information relative to the



1 information from the case records of patients after care  
2 is terminated and provides data related to such informa-  
3 tion as age groups, diagnosis and duration of nursing  
4 service. Statistics from these sources are published  
5 annually.

6 An audited financial statement is prepared  
7 and published annually for the national office of the  
8 Victorian Order and for each of its branches. These state-  
9 ments show receipts and disbursements.

10 Information from the statistical and finan-  
11 cial reports will be quoted in further submissions.

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Information from the case records of patients after care

is terminated and provides data related to such information

tion as age group, diagnosis and duration of nursing

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SUBMISSION OF

THE VICTORIAN ORDER OF NURSES FOR CANADA

---

A. INTRODUCTION

The Victorian Order of Nurses for Canada is a national, voluntary, public health nursing organization with headquarters in Ottawa. Branches have been established in all provinces with the exception of Prince Edward Island. These branches are located in 118 cities, towns and counties across Canada. More than 650 nurses are employed by the Order.

The purpose of this preliminary statement is to provide background material relating to the origin and development of the Victorian Order, its objectives and administration as well as the general policies under which service is given in all branches. This information is presented to assist the members of the Commission in their consideration of further provincial and national submissions.

B. SUMMARY

L. With the founding of the Victorian Order of Nurses in 1897, visiting nursing was introduced into Canada. For over 60 years the organization has given leadership in the growth and development of this service. Through its flexible policies and program and its early association with the modern public health movement, the Order has contributed to the development of other public health nursing



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1 services in many communities. The original charter  
2 of the Order was replaced by an Act of Parliament  
3 of Canada which became effective in 1954 and under  
4 which the Victorian Order of Nurses for Canada is  
5 incorporated. The present objectives are stated  
6 in this Act and are included in this submission.  
7 Throughout the years the objectives have indicated  
8 the Order's concern, not only with the care of the  
9 sick, but also with the prevention of illness and the  
10 promotion of health. They have reflected the  
11 organization's responsibility for developing and  
12 extending service, for maintaining the quality of  
13 nursing care given, and for assisting in the training  
14 of personnel.

15 2. From its beginning, the Victorian Order  
16 has sought to plan and adapt its program to the  
17 needs of a community. This has resulted in a  
18 variety of services being offered not only from branch  
19 to branch but from province to province. The pro-  
20 gram in any area is planned in consultation with  
21 local and provincial health authorities and is carried  
22 on in cooperation with hospitals and other health  
23 and social agencies, both official and voluntary.  
24 All branches of the Victorian Order accept the basic  
25 policies of the national organization relating to the  
26 care of patients.

27 The primary function of the Order is to  
28 provide skilled nursing care to patients in their  
29 homes on a visit basis and to combine with this care,  
30 health teaching to the patient and family. This



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1 care is available in all branches to anyone in the com-  
2 munity regardless of age, sex, creed or financial  
3 status. It is available on a 24-hour basis for all  
4 types of illness, acute, chronic or convalescent and  
5 to mothers and babies. Other services are offered  
6 in many branches. These activities are undertaken  
7 to fill a need for service which is not being offered  
8 by another agency, to contribute to a more compre-  
9 hensive service in a community through sharing a  
10 program with another agency, or to initiate or  
11 demonstrate a service which should be developed.  
12 Student field experience or observation is provided  
13 for nursing and medical students.

14 3. Policies and standards are set at the  
15 national level and are accepted by all branches. The  
16 conduct of the affairs of the Order is the respon-  
17 sibility of a national board of governors and of  
18 boards of management and committees at the national,  
19 provincial and local level. This voluntary citizen-  
20 ship participation is a fundamental principle of the  
21 organization. The administration, supervision and  
22 development of the nursing service is the respon-  
23 sibility of the nursing staff of the Order. The  
24 structure of the organization provides for liaison  
25 between the national, provincial and local levels.

26 4. To maintain and improve the quality of  
27 nursing care provided, standards regarding the  
28 qualifications and employment of staff have been  
29 established. For staff positions, preparation  
30 in public health nursing is desired and, in



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1 employment, preference is given to nurses with this  
2 qualification. For administrative and supervisory  
3 positions, preparation in administration and super-  
4 vision in public health nursing is desired and, for  
5 senior positions, is required. All nurses are  
6 registered in the province in which they are employed.  
7 A small group of nursing assistants is employed in  
8 three of the large branches of the Order.

9 To assist nurses to obtain public health  
10 nursing qualifications, bursaries are offered each  
11 year by the national organization. In-service educa-  
12 tion programs, library facilities and attendance at  
13 refresher courses assist staff in maintaining the  
14 quality of service.

15 A guide for personnel policies has been  
16 drawn up by the national organization to provide a  
17 basis on which personnel policies in the branches  
18 may be established. A pension plan for all employees,  
19 nursing or clerical, is administered by the national  
20 office.

21 5. The boards of management at the national,  
22 provincial and local level are responsible for securing  
23 the necessary funds to carry on Victorian Order programs.  
24 Each branch is responsible for financing the service  
25 in its area. The average cost for Victorian Order  
26 service in each branch is computed annually on a visit  
27 basis. The same costing system is used by all branches.  
28 Because of the type of area served, the size, location  
29 and the type and amount of service given costs vary  
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6. Statistical information from the service records of the Victorian Order is available from two sources. One method produces information relating to the current volume of service given. The other method secures information from the case records of patients after care is terminated and provides data related to such information as age groups, diagnosis and duration of nursing service. Statistics from these sources are published annually.

An audited financial statement is prepared and published annually for the national office of the Victorian Order and for each of its branches. These statements show receipts and disbursements.

Information from the statistical and financial reports will be quoted in further submissions.

#### C. ORIGIN AND DEVELOPMENT

With the founding of the Victorian Order of Nurses in 1897, visiting nursing was introduced into Canada. Established by Royal Charter as a result of resolutions presented from Vancouver and Halifax at the annual meeting of the National Council of Women, the organization had as its first president Lady Aberdeen. Since that time each succeeding Governor General has extended his patronage to the Order.

From the beginning the Victorian Order has sought to plan and adapt its program to the needs of a community, and has included a variety of types of service. Although originally intended primarily for





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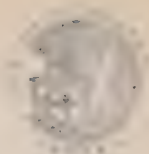
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1 service in country districts, branches were also  
2 formed in urban centres, some of the earliest being  
3 Ottawa, Montreal, Toronto, Halifax, Vancouver and  
4 Kingston. To meet a need for hospital facilities in  
5 areas where visiting nursing was then impractical,  
6 small cottage hospitals were established. From 1898  
7 onwards some 44 such hospitals were operated by the  
8 Order. As municipalities became organized these  
9 hospitals were handed over to local authorities and  
10 by 1924 this phase of the work had been discontinued.

11 Visiting nursing is acknowledged to be one  
12 of the foundations on which public health nursing is  
13 built. Following World War 1 the Victorian Order  
14 became an active participant in the developing field  
15 of public health in Canada. At this time the pre-  
16 ventive aspects of the service were more fully  
17 recognized, the teaching function of the visiting  
18 nurse was emphasized and preparation in public health  
19 nursing was introduced as the desirable qualification  
20 for employment. Although continuing its visiting  
21 nursing function, the Victorian Order, in this period,  
22 assisted in meeting the great need for general public  
23 health nursing services.

24 In many communities across Canada the Victorian  
25 Order offered the complete public health nursing ser-  
26 vice including schools, child health conferences,  
27 immunization clinics, etc. As official public health  
28 nursing agencies have developed, the Victorian Order  
29 has withdrawn from these services in many communities.  
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1 health authorities, these services are still maintained  
2 or they are shared with the official agency. In 1952  
3 a survey of the Victorian Order was conducted.  
4 Following this the original charter was replaced by an  
5 Act of Parliament of Canada which became effective  
6 in 1954 and under which the Victorian Order of Nurses  
7 for Canada is incorporated. This Act provided for the  
8 establishment of provincial organizations.

9  
10 D. OBJECTIVES

11 From its establishment in 1897, the objectives  
12 of the Victorian Order have indicated the Order's  
13 concern, not only with the care of the sick, but  
14 also with the prevention of illness and the promotion  
15 of health. Throughout the years these objectives have  
16 also reflected the organization's responsibility for  
17 maintaining the quality of the service and for assist-  
18 ing in the training of personnel. The present stated  
19 objectives are essentially as follows:

- 20 1. To establish, maintain and carry on a  
21 visiting nursing service in Canada and to  
22 aid in the prevention of disease and the  
23 promotion of health.
- 24 2. To establish, maintain and elevate standards  
25 of nursing service.
- 26 3. To assist in the preparation of nurses for  
27 public health nursing.
- 28 4. To promote the formation of provincial and  
29 local corporations or organizations having  
30 the same objectives.
5. To create branches of the Order.



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1 E. PROGRAM

2 The program of the Victorian Order is  
3 planned in consultation with the proper local and  
4 provincial health authorities and is carried on in co-  
5 operation with hospitals and other health and social  
6 agencies, both official and voluntary. While its  
7 primary function is the provision of visiting nursing  
8 service, other services are provided in many communi-  
9 ties. These activities are undertaken to fill a  
10 need for service which is not being offered by another  
11 agency, to contribute to a more comprehensive service  
12 to a community through sharing a program with another  
13 agency, or to initiate or demonstrate a service which  
14 should be developed. While no two branches are exactly  
15 alike in the scope of the service offered, each branch  
16 accepts the basic policies of the national organiza-  
17 tion relating to the care of patients. At all times  
18 it is the desire of the Order to work closely  
19 with other health agencies in a community to provide  
20 a more comprehensive health service to its citizens  
21 without duplication or overlapping.

22 1. Visiting Nursing Service

23 The primary function of the Victorian Order  
24 is to give skilled nursing care to patients in their  
25 homes on a visit basis, to give instruction in the  
26 care required by patients between visits and to com-  
27 bine with this care, health teaching to the patient  
28 and family. All branches of the Order provide this  
29 service.

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THE VICTORIAN ORDER

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1 principles are accepted:

2 Service is available to anyone in a community  
3 where a branch is organized; to all age groups re-  
4 gardless of sex, race, creed or financial status;  
5 for any type of illness, acute, chronic or convales-  
6 cent; for patients during the maternity cycle and for  
7 newborn infants.

8 All patients receiving care must be under  
9 the medical supervision of a qualified physician.

10 Nursing care is provided, administered and  
11 supervised by qualified nursing personnel.

12 The need of the patient for care is the  
13 basis for determining the amount of service given;  
14 visits may be given as often as once or twice a day  
15 or as seldom as once or twice a month; a patient may  
16 be visited only once or may receive care over several  
17 years.

18 According to the need of the patient, ser-  
19 vice is available 24 hours a day, seven days a week.  
20 Service at night and on Sundays and holidays is avail-  
21 able for acutely ill patients, emergencies or home  
22 deliveries.

23 Although in recent years an increasing  
24 amount of the service provided by the Order has been  
25 given for the care and rehabilitation of patients with  
26 acute, convalescent and long term illness, the care  
27 of mothers and babies is still an important part of  
28 the program and is carried out in cooperation with  
29 other public health nurses working in the community.  
30 Provision is still made for assistance at home



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1 deliveries.

2 2. Other Services

3 In addition to nursing care in the home,  
4 which is offered by all branches, other services have  
5 been undertaken in many branches. These include -

6 (a) Group Teaching

7 Classes for expectant mothers and parents'  
8 classes are either conducted under the auspices of the  
9 Victorian Order, or the Order participates in a  
10 community program with the official agency or other  
11 voluntary health organizations.

12 (b) Co-ordination of Service between Hospital and Home

13 With the growing emphasis on the care of  
14 patients in the home, particularly those who are dis-  
15 charged from hospital still requiring nursing care,  
16 the Victorian Order is vitally interested in plans  
17 which will make for coordination of services in the  
18 community and for better liaison with the hospital  
19 personnel.

20 Recognizing that a close liaison with hos-  
21 pitals would facilitate the referral of patients for  
22 nursing service and ensure continuity of nursing care  
23 from the hospital to home, a number of Victorian Order  
24 branches have cooperated with hospitals in developing  
25 a referral program. In such programs a nurse from  
26 the staff of the Victorian Order acts in a liaison  
27 capacity between the hospital and the home.

28 (c) Infant, Pre-School, School Health Service

29 In a number of branches, the Victorian Order  
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Recognizing that a close liaison with hospitals would facilitate the referral of patients for nursing services and ensure continuity of nursing care from the hospital to home, a number of Victorian Order branches have cooperated with hospitals in developing a referral program. In such programs a nurse from the staff of the Victorian Order acts in a liaison capacity between the hospital and the home.

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1 health nursing service given in these areas including  
2 child health conferences and immunization clinics.  
3 In other branches the Order assists at conferences  
4 and clinics conducted by the official agency. Arrange-  
5 ments for these services are made in cooperation with  
6 the local and provincial official health agencies.

7 (d) Occupational Health Service

8 In response to a need expressed by small  
9 industries for a part-time nursing service for their  
10 employees, the Victorian Order has, within recent  
11 years, developed a part-time service in this area of  
12 nursing and is now offered in over 20 communities.  
13 Essentially a health counselling service, it is only  
14 offered to industries which would not be large enough  
15 to employ a full-time nurse.

16 3. Student Field Experience

17 The Victorian Order contributes to the  
18 education of professional personnel in all its branches.  
19 Although priority is given to providing field practice  
20 experience for both undergraduate and graduate nurses  
21 who are being prepared in public health nursing at  
22 university schools of nursing, a large number of  
23 branches also provide an observation period for under-  
24 graduated nursing students in hospital schools of  
25 nursing. A few branches provide observation for  
26 medical students.

27 F. ORGANIZATION AND ADMINISTRATION

28 The conduct of the affairs of the Order  
29 is the responsibility of a national board of governors  
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Student Field Experience

The Victorian Order contributes to the education of professional personnel in all its branches. Although priority is given to providing field practice experience for both undergraduate and graduate nurses who are being prepared in public health nursing at university schools of nursing, a large number of branches also provide an observation period for undergraduate nursing students in hospital schools of nursing. A few branches provide observation for medical students.

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9 The administration, supervision and  
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12 1. The Board

13 (a) Under the Act of Parliament of 1954, the  
14 general control of the affairs of the Order were vested  
15 in a board of governors which meets annually and  
16 which includes in its membership at least one repre-  
17 sentative from each branch of the Order and repre-  
18 sentatives from the national and provincial nursing  
19 and medical associations. In between annual meet-  
20 ings the powers of the board are delegated to a  
21 board of management. Committees of the board of  
22 management include: administrative, advisory nursing,  
23 investment and finance, annuities and benefits, educa-  
24 tion and publicity. Members of the medical profes-  
25 sion are appointed by the national board to advise on  
26 matters of medical significance.

27 (b) Local Level

28 Each local branch, the majority of which  
29 are incorporated, has a local board of management  
30 responsible for maintaining the service in the area



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The administration, supervision and development of the nursing service is the responsibility of the nursing staff of the Order.

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(a) Under the Act of Parliament of 1954, the general control of the affairs of the Order were vested in a board of governors which meets annually and which includes in its membership at least one representative from each branch of the Order and representatives from the national and provincial nursing and medical associations. In between annual meetings the powers of the board are delegated to a

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#### (b) Local Level

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1 and wholly responsible for its financing. Committees  
2 of the board at one local level are similar to those  
3 at the national level. Each board has a medical  
4 advisory committee which is representative of the  
5 local medical society and local physicians. Each  
6 branch accepts the professional standards and poli-  
7 cies of the national organization.

8 (c) Provincial Level

9 Incorporated provincial organizations have  
10 been established in seven provinces, namely, British  
11 Columbia, Alberta, Saskatchewan, Ontario, Quebec, New  
12 Brunswick and Nova Scotia. Their purpose is to allow  
13 for a closer relationship between the Order and pro-  
14 vincial governments, without disturbing the direct  
15 contact between the branches and national office, and to  
16 obtain appropriate financial support for service ren-  
17 dered provincially.

18 2. The Nursing Staff

19 (a) National Level

20 The Director in Chief is responsible to the  
21 national board of management for all aspects of the  
22 service rendered to patients, including the standard of  
23 care, the adequacy of staff, the development of program  
24 and the statistical recording and reporting of service.  
25 In addition to an assistant director and educational  
26 director, nine regional directors are employed at  
27 the national level, each of whom is responsible for the  
28 supervision of branches in a designated area of Canada.

29 (b) Local Level

30 At the local level all staff are appointed to



and wholly responsible for its financing. Committees of the board at one local level are similar to those at the national level. Each board has a medical advisory committee which is representative of the local medical society and local physicians. Each branch accepts the professional standards and policies of the national organization.

### (c) Provincial Level

Incorporated provincial organizations have been established in seven provinces, namely, British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, and Nova Scotia. Their purpose is to allow for a closer relationship between the Order and provincial governments, without disturbing the direct contact between the branches and national office, and to obtain appropriate financial support for service re-

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### (d) Local Level



1 the branch on the recommendation of the national  
2 office and must meet its professional qualifications.  
3 While some nurses may be recruited locally, the  
4 national office assumes the ultimate responsibility  
5 to fill vacancies. Transer of staff from one branch  
6 to another is also arranged through the national  
7 office. In each branch employing one to five nurses,  
8 one nurse is designated as nurse in charge. In  
9 the larger branches the nursing administrator is  
10 called a district director. In addition to this  
11 permanent staff, relief nurses are employed to meet  
12 increased service demands of an emrgency or seasonal  
13 nature. When such demands become regular the em-  
14 ployment of additional staff on a permanent basis is  
15 recommended. The number of nurses required in a  
16 branch is affected by the demand for service, by the  
17 type of program carried and by the type of area  
18 served.

19 (c) Provincial Level

20 No nursing staff is employed by provincial  
21 organizations. Nursing representation on the pro-  
22 vincial board of management is secured through the  
23 appointment of one or more nurses from local branches to  
24 the board. The regional director assigned to the area  
25 by the national office acts in a consultant capacity  
26 to the provincial group.

27  
28 3. Liaison between the national, pro-  
29 vincial and local levels

30 This is provided by a representative from  
each local branch to the national board of governors





the branch on the recommendation of the national office and must meet the professional qualifications. While some nurses may be recruited locally, the national office assumes the ultimate responsibility to fill vacancies. Transfer of staff from one branch to another is also arranged through the national office. In each branch employing one to five nurses, one nurse is designated as nurse in charge. In the larger branches the nursing administrator is called a district director. In addition to this permanent staff, relief nurses are employed to meet increased service demands of an emergency or seasonal nature. When such demands become regular the employment of additional staff on a permanent basis is recommended. The number of nurses retained in a branch is affected by the demand for service, by the type of program carried and by the type of area.

### (c) Provincial Level

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1 and a representative from each provincial organiza-  
2 tion to the national board of management. In  
3 addition the regional directors employed by the national  
4 office, act in a supervisory and consultant capacity  
5 to the local branches and to the provincial organiza-  
6 tions.

7 A council of nurses acts in an advisory  
8 capacity to the Director in Chief. This council meets  
9 at least once every two years and is composed of the  
10 professional staff employed by the national office  
11 and the district directors of the 22 branches employing  
12 six or more full-time nurses.

13 G. STONEHOUSE PERSONNEL

14 To maintain and improve the quality of nursing  
15 care provided by the Victorian Order, standards re-  
16 garding the qualifications and the employment of  
17 staff are established by the national organization.

18 1. Qualifications for Nursing Personnel

19 (a) Staff

20 Preparation in public health nursing obtained  
21 at a university school of nursing is desired. In  
22 employment, preference is given to nurses with this  
23 qualification. With a few exceptions, this qualifi-  
24 cation is required for nurses appointed in charge of  
25 branches. Registered nurses interested in working  
26 in the community are employed in staff positions and  
27 are encouraged to obtain preparation in public health  
28 nursing. Nursing assistants who have completed an  
29 approved course of training and obtained provincial  
30 recognition are employed by three of the large branches.



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1 (b) Administrative and Supervisory Personnel

2 Requirements for these positions include  
3 preparation in public health nursing and a demonstrated  
4 leadership ability. Experience in the field of  
5 visiting nursing is desirable and, wherever possible,  
6 preparation in administration and supervision ob-  
7 tained at a university school of nursing is required.  
8 For senior positions in the Order all appointments must  
9 have such qualifications, preferable at a degree level.

10 2. Educational Opportunities

11 The Victorian Order recognizes that a high  
12 quality of service can only be maintained through the  
13 growth and development of its staff.

14 (a) Bursaries

15 Bursary assistance is offered by the national  
16 organization and by several local branches to registered  
17 nurses enrolled in courses in public health nursing at  
18 a university school of nursing; to undergraduate students  
19 in their final year of a basic degree program at a  
20 university school of nursing; and to experienced public  
21 health nurses enrolled in advanced courses in public  
22 health nursing administration and supervision, either  
23 at the degree or certificate level.

24 (b) In-service Education

25 Programs for orientation of new staff and  
26 for the continuing education of all staff are planned  
27 and implemented through the educational director and  
28 regional directors employed by the national office as  
29 well as through the administrative and supervisory  
30 personnel in the branches. In recent years regional



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1 institutes on rehabilitation nursing have been con-  
2 ducted in many parts of Canada by the educational  
3 director employed by the national office.

4 Libraries are maintained by the national  
5 office and by a number of large branches from which  
6 books and periodicals are available to all staff.  
7 Reference material is available in each branch. The  
8 educational director in the national office also  
9 assists staff in obtaining current information on new  
10 developments in the nursing care of patients.

11 In addition to its own staff development  
12 program, the Victorian Order encourages staff atten-  
13 dance at the various refresher courses and institutes  
14 sponsored by university schools of nursing and atten-  
15 dance at professional meetings.

### 16 3. Personnel Policies

17 A guide for personnel policies has been  
18 drawn up by the national organization to provide  
19 a basis on which personnel policies in the branches may  
20 be established. Included are requirements for appoint-  
21 ment, suggested hours of work, vacation, sick leave,  
22 statutory holidays, health program transportation,  
23 salary, etc. In the various provinces salary recom-  
24 mendations are based on schedules approved by the  
25 appropriate provincial registered nurses' association.  
26 The schedules recommended by the Canadian Public Health  
27 Association and salaries paid to comparable workers  
28 in the area are also considered. The national office  
29 recommends that, wherever possible, clerical personnel  
30





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1 be employed to release professional staff for nursing  
2 activities. Recommendations are made by the national  
3 organization to the branches regarding coverage for  
4 accidents and malpractice.

#### 5 4. Pension Plan

6 The Victorian Order pension plan is open to all  
7 employees who have completed one year of service. It  
8 is compulsory for all employees to join the plan after  
9 two years of service. The employee contributes 5 per  
10 cent of her salary, the employing branch pays a similar  
11 amount and the national organization makes up the  
12 difference required to provide the benefits. The  
13 plan is administered by the national office.

#### 14 H. FINANCING

15 The Victorian Order of Nurses is a voluntary,  
16 non-profit organization. The boards of management at  
17 the national, provincial and local level are responsible  
18 for securing the necessary funds to carry out its  
19 program.

##### 20 1. The National Office

21 The program of the national office is, in  
22 the main, financed by funds secured nationally through  
23 national appeals conducted at five-year intervals and  
24 from endowments. An annual grant is received from the  
25 Department of Health and Welfare.

26 Services provided by the national office to  
27 the branches include: professional consultation and  
28 supervision, placement and transfer of nurses, assis-  
29 tance in maintaining qualified staff through bursaries  
30 for public health nursing preparation; maintenance of

be employed to release professional staff for nursing activities. Recommendations are made by the national organization to the branches regarding coverage for accidents and malpractice.

#### 4. Pension Plan

The Victorian Order pension plan is open to all employees who have completed one year of service. It is compulsory for all employees to join the plan after two years of service. The employee contributes 5 per cent of her salary, the employing branch pays a similar amount and the national organization makes up the difference required to provide the benefits. The plan is administered by the national office.

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national financial and statistical records and consultants service; administration of pension plan, etc. Each branch is charged a professional service fee which is computed annually on the basis of the number of visits made by the branch in the preceding year at a rate of  $2\frac{1}{2}$  cents per visit, with a minimum charge of \$50.00, a maximum of \$500.00. It is acknowledged that the charge does not cover the cost but is a recognition of services given on a nationwide basis.

## 2. The Local Branch

Each local branch is responsible for financing the services in its area. The main sources of revenue include fees from patients, community appeals, either through a community chest or a local campaign; municipal and provincial grants, contracts with Department of Veterans' Affairs, insurance companies, etc., gifts and bequests. Contracts have been made, usually at a national level with some insurance companies and other agencies such as the Department of Veterans' Affairs. Under such contracts each branch is paid for service to eligible patients on the basis of its annual cost per visit. In some provinces the provincial organization of the Victorian Order has assisted the local branches in obtaining funds from provincial governments.

## 3. Computation of Cost of Service

The cost of Victorian Order service is computed annually for each branch on the basis of the average cost per visit for the branch. The same costing system is used by all branches and includes



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4 was adopted from a study of recording and cost analyses  
5 made by the national organization of Public Health  
6 Nursing in the United States and is similar to costing  
7 systems of visiting nursing organizations in the  
8 United States. Because of type of areas served, size,  
9 location and type of and number of visits, costs vary  
10 from branch to branch. The full fee for service  
11 charged by a branch is based on its average cost per  
12 visit.

#### 13 I. STATISTICAL AND FINANCIAL REPORTING

14 Statistical information from the service  
15 records of the Victorian Order of Nurses for Canada is  
16 made available by means of two kinds of reporting  
17 systems. Selected information from both sources will  
18 be quoted in further submissions. Statistics from  
19 the two sources are not comparable.

20 One method secures statistics from the nurses'  
21 daily activity reports and produces a picture of the  
22 volume of service rendered during a period of time.  
23 Compiled at the branch level, this information is sent  
24 by each branch on a monthly basis to the national office.  
25 The annual statistics reported by this method are  
26 published in the Annual Report of the organization and  
27 are available by branch, by province and for all of  
28 Canada.

29 The other method classifies information from  
30 the case records of patients, after care is terminated,





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1 and shows service given from the date of admission to  
2 the date of discharge. The statistics from these dis-  
3 missed case records are compiled at the national level  
4 and published annually by the Public Health Section,  
5 Dominion Bureau of Statistics in a report "Statistics  
6 of Home Nursing Service (Victorian Order of Nurses for  
7 Canada)." These data are related to age groups,  
8 diagnosis, duration of nursing service, payment, sex,  
9 and marital status.

10 An audited financial statement is prepared and  
11 published annually for the national office of the  
12 Victorian Order and for each of its branches. These  
13 statements show receipts and disbursements.

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15 reports will be quoted in further submissions.

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J. REFERENCES

Emory, Florence H.M., "Public Health Nursing in Canada." Revised Edition, Toronto: The MacMillan Company of Canada Limited, 1953.

"Report of the Survey Commission," Ottawa Victorian Order of Nurses for Canada, 1953.

"Statistics of Home Nursing Services (Victorian Order of Nurses for Canada)" Ottawa: Dominion Bureau of Statistics, Health and Welfare Division, Public Health Section. Published annually.

Victorian Order of Nurses. "Annual Report and Statistical Supplement". Ottawa: Victorian Order of Nurses for Canada. Published annually.

Victorian Order of Nurses for Canada.

"Charter and By-laws". Ottawa: Victorian Order of Nurses for Canada, 1955.

Victorian Order of Nurses for Canada.

"History, Constitution and Administration." Revised Edition. Ottawa: Victorian Order of Nurses for Canada. 1957.

Victorian Order of Nurses for Canada.

"Nursing Manual." Revised Edition. Ottawa Victorian Order of Nurses for Canada, 1955.



Emory, Florence H.M., "Public Health Nursing  
in Canada." Revised Edition, Toronto: The Macmillan  
Company of Canada Limited, 1933.

"Report of the Survey Commission," Ottawa  
Victorian Order of Nurses for Canada, 1933.

"Statistics of Home Nursing Services  
(Victorian Order of Nurses for Canada)," Ottawa:  
Dominion Bureau of Statistics, Health and Welfare  
Department, 1933.

Victorian Order of Nurses, "Annual Report  
and Statistical Supplement," Ottawa: Victorian Order  
of Nurses for Canada. Published annually.

Victorian Order of Nurses for Canada.  
"Chapter and By-Laws." Ottawa: Victorian Order of  
Nurses for Canada.

Victorian Order of Nurses for Canada.  
"History, Constitution and Administration." Revised  
Edition. Ottawa: Victorian Order of Nurses for  
Canada.

Victorian Order of Nurses for Canada.  
"Order of Nurses for Canada, 1935."



1 Mr. Chairman, I think we indicated at the  
2 preliminary hearing in September that the intention of  
3 the Victorian Order of Nurses for Canada is to submit  
4 their main brief at the conclusion of the Provincial  
5 submissions, and it is expected at that time that we  
6 would be making recommendations to the Commission, and I  
7 would be very glad to elaborate on its policies in  
8 answering questions from the Commission.

9 COMMISSIONER FIRESTONE: Miss Leask, on page  
10 3 you refer to bursaries. How many such bursaries were  
11 awarded, say, in 1960?

12 MISS LEASK: In 1960 we gave 50 bursaries  
13 of a thousand dollars.

14 COMMISSIONER FIRESTONE: A thousand dollars  
15 each?

16 MISS LEASK: A thousand dollars each. In  
17 1961, that is this summer, or this Fall, we have again  
18 awarded 50 bursaries; 45 of them this year were for a  
19 thousand dollars, 5 were for \$1,500, because the 5 this  
20 year were given for nurses who were going to take the  
21 advanced or additional preparation in administration and  
22 supervision, and it was felt necessary for that course  
23 for experienced people, who perhaps have more financial  
24 obligations, or at a place where they need additional  
25 assistance to take an advanced course. So this year we  
26 have given 45 of a thousand dollars and 5 of \$1,500.

27 COMMISSIONER FIRESTONE: Having given those  
28 bursaries, is there any provision whereby you retain the  
29 services of those who have benefited?

30 MISS LEASK: We have an agreement that in



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1 giving these bursaries the nurses who accept them agree  
2 to give one year's service to the Victorian Order wherever  
3 their services are needed. So they agree to be placed  
4 anywhere in Canada where there is a need for their  
5 services. They might be placed in any Province in Canada.  
6 But this is their agreement, that they agree to give ser-  
7 vice to the Victorian Order wherever we place them, and  
8 next Spring we would be placing them.

9 COMMISSIONER FIRESTONE: Have you experienced  
10 any difficulty with that program, or has it worked well?

11 MISS LEASK: I think yes. I think the diffi-  
12 culty is probably minimal in relation to the advantages.  
13 I think if we were not giving these bursaries we would  
14 not be able to certainly staff our branches in particular.  
15 We could place more. We have 50; we could use more.  
16 And I think in relation to recruitment, certainly in the  
17 last two years we haven't had difficulty in recruiting  
18 since we can recruit from all parts of Canada. I think  
19 we have more applications from certain places in Canada  
20 than from others. But I feel we have had more applications  
21 than we have had bursaries for. So I think we are able  
22 to get the applicants when we can recruit them from Canada,  
23 and we could use more.

24 COMMISSIONER BALTZAN: Mr. Chairman, I would  
25 like to know, these bursaries, are they at the national  
26 level, and that is why these people choose or may go to  
27 any place there is a need for them, and if that is the  
28 case - and I can see by your nodding that that is the  
29 case - are there other bursaries which come from, say,  
30 local levels?



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26 any place there is a need for them, and if that is the  
27 case - and I can see by your nodding that that is the  
28 case - are there other nurses which come from, say,  
29 local levels?





1 MISS LEASK: Yes, Mr. Chairman, certain  
2 branches do give bursaries locally, and if they give a  
3 bursary locally, then that person would go back to that  
4 branch, and those would be in addition to those 50.  
5 Perhaps a branch might be able to find the money for two  
6 or three this year and only one next year. But there are  
7 a number of branches who gives bursaries locally, and  
8 these people would return to that branch. But this  
9 national policy gives us a group of people who can be  
10 placed anywhere in Canada.

11 COMMISSIONER STRACHAN: I was wondering why  
12 you wouldn't know when the local bursaries are given,  
13 because that person would be out of your employment.

14 MISS LEASK: We would know in any one year.  
15 It varies from year to year. We would know each year.

16 THE CHAIRMAN: Are you able to say from the  
17 fact of this home nursing care what effect that has on the  
18 utilization or the freeing of hospital beds?

19 MISS LEASK: Mr. Chairman, you are speaking  
20 of the fact that we exist as a home nursing care?

21 THE CHAIRMAN: Yes.

22 MISS LEASK: I think that we probably will  
23 be speaking more about that in our submission. I feel  
24 that perhaps at the present time I could say that when  
25 such a service is available in the home it means that  
26 patients that can be released from hospital requiring  
27 nursing care can go home. We realize in many instances  
28 other services are needed at home. We do feel that there  
29 are three groups in any community that we serve: the group  
30 that never goes to hospital, the group that are cared for

MISS LEASK: Yes, Mr. Chairman, certainly

branches to give businesses locally, and if they give a  
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fact of this home nursing care what effect that has on the  
utilization or the freeing of hospital beds?

MISS LEASK: Mr. Chairman, you are speaking

of the fact that we exist as a home nursing care?

THE CHAIRMAN: Yes.

MISS LEASK: I think that we probably will

be speaking more about that in our submission. I feel

that perhaps at the present time I could say that when

such a service is available in the home it means that

patients that can be released from hospital requiring

nursing care can go home. We realize in many instances

other services are needed at home. We do feel that there

are three groups in any community that we serve: the group

that never goes to hospital, the group that goes to hospital





1 entirely at home and have their total illness at home;  
2 the group that can be kept in the home for a longer period  
3 because there is a nursing service before they need be  
4 institutionalized; and the group that come home still  
5 requiring nursing care. We feel that generally the  
6 payment for hospital care, now that hospital care is paid  
7 for, that patients perhaps do not come home at a time  
8 when they might come home or it is possible to come home.  
9 But in some instances some patients may come home earlier,  
10 but their care is paid for in hospital, and in the home  
11 they perhaps have to pay for it themselves, and this is  
12 probably one reason why the service is not being used as  
13 extensively.

14 THE CHAIRMAN: Thank you very much.

15 COMMISSIONER FIRESTONE: Can we expect from  
16 you, Miss Leask, when your main brief becomes available,  
17 information on the total financial implications of some  
18 of the recommendations you are planning to submit and how  
19 it can be paid for or proposals how it can be paid for?

20 MISS LEASK: You are meaning in extension  
21 of the service?

22 COMMISSIONER FIRESTONE: Yes.

23 MISS LEASK: Yes, I would think that we  
24 would go into - we would need to go into the finances  
25 since that is one of our difficulties.

26 COMMISSIONER FIRESTONE: So you would be  
27 providing us with a projected budget of your requirements  
28 and how it can be met?

29 MISS LEASK: I would certainly think we  
30 would do our best to do that, yes.





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the group that can be kept in the home for a longer period  
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COMMISSIONER FINESTONE: Can we expect from

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MISS LEASK: You are hearing in extension

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would go into - we would need to go into the finances

since that is one of our difficulties.

COMMISSIONER FINESTONE: So you would be

providing us with a projected budget or your requirements

and how it can be met?

MISS LEASK: I would certainly think we

would be at least to do that, yes.



1 COMMISSIONER FIRESTONE: Thank you very much.

2 THE CHAIRMAN: Thank you.

3 THE SECRETARY: Mr. Chairman, could the last  
4 submission be known as Exhibit 10?

5 THE CHAIRMAN: Yes.

6  
7 --- EXHIBIT NO. 10: Submission of The Victorian Order of  
8 Nurses for Canada.

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submission be known as Exhibit 10?

THE CHAIRMAN: Yes.

--- EXHIBIT NO. 10: Submission of The Victorian Order of





SUBMISSION OF THE VICTORIAN ORDER OF NURSES

FOR NOVA SCOTIA

Appearances: Mrs. G.G. Reid  
Mrs. C.J. Creighton  
Miss L. Wall  
Mr. P.J. Lee

MRS. REID: Branches of the Victorian Order of Nurses for Canada were established in Nova Scotia soon after the founding of the organization in 1897. At the present time service is available in fifteen communities in the province. Because of its historical development as one of the first public health nursing organizations in Nova Scotia, the Order has a varied program in the province. The majority of branches either provide or assist in providing a generalized public health nursing service. These programs have been developed in co-operation with the provincial Department of Public Health. In accordance with national policy, the branches in Nova Scotia will continue to provide such services as long as there is a need.

Since the provision of nursing care in the home is the primary function of the Victorian Order, ways and means of extending this service are important considerations. Through its fifteen branches this service is now available to 38% of the population in Nova Scotia. Four other areas have expressed a need for service to be established. Present methods of financing make the extension of existing territories and the provision of service in new areas difficult.

The Victorian Order believes that many patients could be cared for at home. With the present



Mrs. C. J. O'Brien  
Miss L. Wall  
Mr. P. J. Lee

MRS. R. M. D. Branches of the Victorian Order

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with the provincial Department of Public Health. In some

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now available to 30% of the population in Nova Scotia.

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patients could be cared for at home. With the present



1 strain on hospital facilities it would appear that the  
2 provision for adequate care at home should be seriously  
3 considered. The development of liaison programs with  
4 hospitals, one of which is already in operation, would  
5 provide for more continuity of nursing care. A further  
6 step in providing adequate care would be the initiation of  
7 organized home care programs which include, as well as  
8 visiting nursing, a range of other services. It is the  
9 desire of the Victorian Order to see such programs initiated  
10 in Nova Scotia and because of its experience in visiting  
11 nursing believes it could give valuable assistance in  
12 this area.

13 As a voluntary agency, one of the roles of  
14 the Order is to experiment in the provision of new ser-  
15 vices or in the extension of existing services. The  
16 Victorian Order is willing to co-operate in any program  
17 which will strengthen and co-ordinate health services in  
18 Nova Scotia.

19 B. PRESENT FACILITIES

20 1. Areas Served

21 Victorian Order service has been provided  
22 in Nova Scotia since the early beginnings of the  
23 Order. The Halifax branch was one of the first four  
24 branches to be organized in Canada in 1898. The new-  
25 est branch, North Sydney, opened in May 1960.

26 Fifteen branches of the Order are located  
27 in cities and towns extending from Yarmouth to  
28 Sydney.

29

30





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 2 provision for adequate care at home should be seriously  
 3 considered. The development of liaison programs with  
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1 Eight of these branches make service available beyond  
2 the city or town boundaries, one even extending as far  
3 as fourteen miles. The fifteen branches are located  
4 in Amherst, Bridgewater, Dartmouth, Digby, Halifax,  
5 Kentville, Liverpool, New Glasgow, North Sydney,  
6 Pictou, Sydney, Truro, Windsor-Hantsport, Wolfville  
7 and Yarmouth.

8 Through the branches at present organized  
9 in Nova Scotia, Victorian Order services are  
10 available to a total population of approximately  
11 272,000 or 38 per cent of the total estimated  
12 population of the Province (June 1960 estimated  
13 population 723,000 obtained from Dominion Bureau of  
14 Statistics).

## 15 2. Organization

16 All branches in Nova Scotia are incorporated.  
17 Each branch has its own board of management which is  
18 comprised of between fifteen to twenty men and women  
19 who are elected at an annual meeting and serve as  
20 voluntary board members. The executive and committees  
21 are appointed from among the board members and it  
22 is their responsibility to manage the affairs of the  
23 branch, maintain the service and obtain the financial  
24 support. The board meets at regular intervals,  
25 usually monthly. In many of the branches the district  
26 medical officer of health is a member of the board  
27 and thus a close relationship is maintained between  
28 the Victorian Order of Nurses and the Department of  
29 Public Health.

30 The Victorian Order of Nurses for Nova Scotia

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Through the branches at present organized in Nova Scotia, Victorian Order services are available to a total population of approximately 275,000 or 38 per cent of the total estimated population of the Province (June 1950 estimated population 725,000 obtained from Dominion Bureau of Statistics).

## 2. Organization

All branches in Nova Scotia are incorporated. Each branch has its own board of management which is comprised of between fifteen to twenty men and women who are elected at an annual meeting and serve as voluntary board members. The executive and committees are appointed from among the board members and it is their responsibility to manage the affairs of the branch, maintain the service and obtain the financial support. The board meets at regular intervals, usually monthly. To many of the branches the district medical officer of health is a member of the board and thus a close relationship is maintained between the Victorian Order of Nurses and the Department of





1 is a provincial corporation formed to promote within  
2 the province the aims and objectives of the Victorian  
3 Order of Nurses for Canada. The provincial corporation  
4 is concerned with all matters affecting the work of  
5 the Order on a province-wide scale. It is governed  
6 by representatives elected annually from the boards  
7 of each branch throughout the province and one nurse  
8 representative appointed by the nursing staff of the  
9 branches. The regional director assigned to Nova  
10 Scotia by the national office is an ex-officio member.

### 11 3. Program

12 In 1960, 72,935 visits were made to give care  
13 and instruction to 12,822 patients. A comparison of  
14 totals for previous years shows no significant change  
15 in the past five years. Although the majority of  
16 patients admitted were mothers and babies, the majority  
17 of visits were to patients admitted with medical and  
18 surgical conditions or for health counselling. It  
19 would also appear that an increasing amount of  
20 visiting nursing time is being given to the care of  
21 patients with chronic illness and those in the older  
22 age group. Detailed statistical information on  
23 service is given in Appendix I.

24 From records of medical and surgican patients  
25 dismissed from Victorian Order care in 1960, over one-  
26 quarter had been hospitalized prior to being referred  
27 for visiting nursing care. To avoid delay and provide  
28 for continuity of service to the patients who still  
29 require care on discharge from hospital, a formal  
30 referral program has been arranged cooperatively between



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In 1960, 73,937 visits were made to give care and instruction to 12,822 patients. A comparison of totals for previous years shows no significant change in the last five years. Although the majority of patients admitted were mothers and babies, the majority of visits were to patients admitted with medical and surgical conditions or for health counselling. It would also appear that an increasing amount of visiting nursing time is being given to the care of patients with chronic illness and those in the older age group. Detailed statistical information on service is given in Appendix I.

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1 the Halifax branch of the Victorian Order and the  
2 Victoria General Hospital. Since the Victoria General  
3 is a provincial hospital and patients are from various  
4 parts of the province this also assists referrals to  
5 other branches. In addition, several branches are  
6 investigating the possibility of referral programs  
7 with the hospitals in their local areas.

8 In Nova Scotia, many of the branches were  
9 organized before there was an official public health  
10 agency and the Victorian Order program was drawn up in  
11 an attempt to fill the needs of the communities.  
12 Many of the activities originally undertaken are still  
13 being provided by the Victorian Order or are shared  
14 with the official group. Eight branches provide  
15 school health services and eleven branches conduct  
16 child health conferences, one of which is being  
17 held jointly with the official agency. Ten branches  
18 provide immunization clinics and five others assist  
19 the Department of Public Health staff in this activity.  
20 Three branches assist at prenatal classes conducted  
21 by the Department of Public Health; in one branch a  
22 nurse attends the hospital prenatal clinic and another  
23 branch conducts a school dental clinic. Joint con-  
24 ferences between the staff of the Department of Public  
25 Health and the Victorian Order nurses are frequently  
26 held. Close relationships exist with other health  
27 and welfare agencies in the communities.

28 To assist in the preparation of nurses,  
29 Victorian Order branches provide experience in home  
30 visiting for student nurses. Six branches provided





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 are also conducting classes and giving advice.

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 held. These conferences have been very helpful  
 and welfare agencies in the communities.

To assist in the preparation of nurses,  
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 visiting for student nurses. Six branches provided



1 observation periods of one or two days each for 113  
2 undergraduate students during 1960. Six branches gave  
3 a three week field experience to each of ten graduate  
4 nurses taking university courses in public health  
5 nursing.

#### 6 4. Personnel

7  
8 The fifteen branches in Nova Scotia employ  
9 a total of forty-three nurses. The branches vary in  
10 size from Halifax, the largest, employing twelve nurses  
11 to the small branches which employ one nurse. Of the  
12 forty-three nurses, twenty have public health nursing  
13 qualifications. One district director has preparation  
14 in supervision and administration. In addition  
15 to the permanent staff, the branches employ relief nurses  
16 to meet increased service demands or to substitute for  
17 the regular staff. This enables the branch to assure  
18 the community that the service is available at all  
19 times on a twenty-four hour basis.

20 Realizing that prepared staff is essential  
21 to maintain a high standard of service, nurses are  
22 encouraged to obtain preparation in public health  
23 nursing. Bursaries are available from the national  
24 organization and of the twenty nurses with this  
25 qualification employed in Nova Scotia, fifteen were  
26 assisted from this source. Since 1952, the province  
27 of Nova Scotia has contributed \$2,500.00 each year to  
28 the bursary fund of the national organization. In  
29 1961, the Department of Public Health of the province  
30 awarded a bursary to a nurse recruited by the Victorian

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#### 4. Personnel

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1 Order on the understanding that she will work in one  
2 of the Nova Scotia branches on the completion of her  
3 course. Another way of assisting staff is through in-  
4 service education. The branches arrange periodic  
5 conferences to study and discuss topics related to  
6 their activities. Attendance at refresher courses  
7 and institutes which are conducted by the universities  
8 is encouraged.

9  
10 5. Office, Telephone and Transportation

11 Each branch maintains an office and adequate  
12 supplies and equipment. In Nova Scotia the majority of  
13 offices are located in public buildings such as  
14 schools, town halls and court houses. In five branches  
15 rent is paid, the remaining offices have been made  
16 available without charge.

17 The telephone is an essential part of the  
18 branch's equipment and arrangements must be made to  
19 provide an answering service on a twenty-four hour  
20 basis. Two branches use a telephone service operated  
21 by a Nurses' Registry. In all other branches, a  
22 voluntary answering service is provided through various  
23 means such as drug stores, hospitals, fire and police  
24 departments.

25 Some means of transportation is essential for  
26 efficient service and it is the responsibility of the  
27 board to see that this is provided. In Nova Scotia  
28 twenty-nine cars are maintained by the fifteen branches,  
29 each branch having at least one car. Many of these  
30 cars have been donated to the branch by a service  
club in the community.

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#### 5. Office, Telephone and Transportation

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efficient service and it is the responsibility of the board to see that this is provided. In Nova Scotia twenty-one cars are maintained by the fifteen branches, each branch having at least one car. Many of these cars have been donated to the branch by a service



6. Finances

In 1960, \$187,065.00 was raised to support Victorian Order service in Nova Scotia. This was done in the following ways:

(a) Municipal grants varying from \$500 to \$5,500 depending on the size of the branch and services provided, were received in each branch. These amounted to 18 per cent of the total amount.

(b) The Provincial Department of Health furnished a grant of \$13,200 which amounted to 7 per cent of the total income and was divided among the branches at the rate of \$300 per nurse.

(c) Money received from nursing fees totalled 21 per cent of all income. Because it is Victorian Order policy to base service on need rather than on the patient's ability to pay, many visits are either part paid or made at no cost at all to the patient. The fee charged the patient is based on actual cost to the branch. Costs in the fifteen branches varied from the lowest of \$1.75 to the highest \$2.95 per visit.

(d) The remaining amount, 54 per cent of the total, was raised by appeals to the public and other sources in the various communities. Six branches are members of united appeals or community chests and the remaining nine conduct their own annual campaigns.

Total disbursements in 1960 amounted to \$182,752.00. The largest item included in this amount was salaries which accounted for 79 per cent of the total. Other amounts were transportation and



In 1950, \$187,000.00 was raised to support  
 Victorian Order service in Nova Scotia. This was done  
 in the following ways:

(a) Manicled gloves varying from \$700

to \$5,500 depending on the size of the branch and

services provided, were received in each branch.

These amounted to 25 per cent of the total amount.

(b) The Provincial Department of

Health furnished a grant of \$13,800 which amounted to

7 per cent of the total income and was divided among

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the total, was raised by appeals to the public and other

sources in the various communities. All branches

are members of United Appeals or community chests and

the remaining nine conduct their own annual campaigns.

Total disbursements in 1950 amounted to

\$187,000.00. The largest item included in this

amount was salaries which accounted for 72 per cent of



1 related expenses 10 per cent, office supplies and  
2 upkeep 4 per cent, and general expenses, including  
3 nursing supplies, insurance pension contributions,  
4 etc. 7 per cent.

5 Each branch has an audited statement of  
6 receipts and disbursements, a summary on a provincial  
7 basis is included in the Appendix II.

8  
9 C. FACTORS AFFECTING VICTORIAN ORDER SERVICE

10 Recently there has been a growing trend  
11 to consider the value of caring for patients in their  
12 own homes. However, it is becoming increasingly diffi-  
13 cult in some areas for the Victorian Order to secure  
14 sufficient funds to maintain the present service or to  
15 extend or undertake any new program. It is felt that  
16 hospital insurance and other prepaid medical care plans  
17 may contribute to this situation. There seems to be  
18 a reluctance on the part of many patients to leave  
19 hospital since care must be paid for at home.

20 The Victorian Order recognizes that nursing  
21 care is only one part of total care of the patient in  
22 the home. Homemaker service is needed in many cases  
23 and may be another reason why patients remain in  
24 hospital longer or must be cared for entirely in  
25 hospital.

26 Frequent staff turnover affects standards of  
27 service. Contributing factors are the levels of  
28 salaries paid and the size of community in which major-  
29 ity of the branches are located. People are inclined  
30 to seek employment in large centres where their services



related expenses 10 per cent, office supplies and  
 telephone 4 per cent, and general expenses, including

etc., 7 per cent.

Each branch has an audited statement of  
 receipts and disbursements, a summary on a proforma  
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Recently there has been a growing trend  
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Contributed centers are the basis of  
 activities and the state of community in which they  
 are located. People are located  
 to seek employment in large centers where their services





1 command higher remuneration and a wider range of social  
2 activity is available.

3  
4 D. POSSIBLE EXTENSION OF SERVICE

5 The Victorian Order is interested in any  
6 plans which would improve the service already being  
7 given, and which would provide service to those areas  
8 not receiving care at the present. Victorian Order  
9 service might be used more extensively to relieve  
10 the present strain on hospital facilities. As a  
11 voluntary agency, one of the roles of the Victorian  
12 Order of Nurses is to experiment in the provision of  
13 new services or in the extension of existing services.  
14 The Order is willing to cooperate in any program which  
15 will strengthen and coordinate health services in  
16 Nova Scotia.

17 Recently the Regional Director for Nova  
18 Scotia has attended meetings in three areas in the  
19 province at the request of groups who would like to  
20 have Victorian Order service established. A fourth  
21 area has also been inquiring as to the possibilities.  
22 The need in these areas seems apparent but the lack  
23 of financial support is an obstacle in organizing  
24 branches. Two of these areas had the benefit of  
25 Victorian Order service in previous years.

26 Existing branches are studying areas in which  
27 they could expand or improve service. In Halifax  
28 some interest has been shown in the development of an  
29 organized home-care plan. Several areas are also  
30 interested in establishing referral systems between  
hospitals and the Victorian Order. As has been



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1 demonstrated already in six branches, an established  
2 branch can extend its boundaries into the surrounding  
3 territory, when there is a need. A branch serving  
4 several small centres or organized on a municipality  
5 or county basis, offers a method of making the service  
6 available and at the same time providing a sufficiently  
7 large population to support the service.





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large population to support the service.



APPENDIX I

Statistical Analysis of Visiting  
Nursing Service for 1960

The two methods of obtaining statistical information has been described in the preliminary statement submitted by the Victorian Order of Nurses for Canada. The following analyses are based on selected data compiled by both methods for the year 1960. The data quoted from the Dominion Bureau of Statistics for 1960 are preliminary and have not yet been published. From information on volume of service for 1960 as shown in Table I we find that 72,935 visits were made to 12,822 patients. Although 59 per cent of the patients were mothers and babies only 23 per cent of the visits were made to them. Patients with medical and surgical conditions accounted for 52 per cent of all visits. Over 14,000 visits or 19 per cent were made for health counselling, the majority 14 per cent being made to infants, pre-school and school age children.



The two methods of obtaining statistical

statement submitted by the Victorian Order of Nurses  
for Canada. The following analyses are based on  
selected data compiled by both methods for the year  
1960. The data quoted from the Dominion Bureau of  
Statistics for 1960 are preliminary and have not yet  
been published. From information on volume of  
service for 1960 as shown in Table I we find that  
12,935 visits were made to 12,882 patients. Although  
45 per cent of the patients were mothers and babies  
only 23 per cent of the visits were made to them.  
Patients with medical and surgical conditions accounted  
for 32 per cent of all visits. Over 14,000 visits  
or 19 per cent were made for health counselling, the  
majority 14 per cent being made to infants, pre-school  
and school age children.





TABLE I

NUMBER OF CASES AND VISITS BY TYPE FOR 1960

Type	Cases	%	Visits	%
Maternity & Newborn (*)	7,546	59.	16,484	23.
Medical & Surgical	5,276	41.	37,928	52.
Health Instruction			14,368	19.
Infant			7,629 )	
Preschool			1,198 )	14.
School			1,319 )	
Adult			4,222	
Other Visits (**)			4,155	6.
Total	12,822	100	72,935	100

(\*) Newborn: age 28 days or less. Visits include 6,870 for health instruction

(\*\*) Patients not seen. On behalf of patient.

Source: Victorian Order of Nurses for Canada,  
Branch Statistics 1960

From data compiled by the Dominion Bureau of Statistics on cases dismissed by the Victorian Order in Nova Scotia in 1960, information is available regarding the age groups of the patients receiving care and the cause and duration of illness. Table II shows that patients with medical or surgical conditions numbered 2,952 and received 41,326 visits. Service was given for as short a period as one day or extended over several years. The majority of these patients (59.4 per cent) received care for less than one month. However, 50 per cent of the visits were to patients who received care for more than one year.



TABLE I

NUMBER OF CASES AND VISITS BY TYPE FOR 1960

TYPE	NUMBER OF CASES	NUMBER OF VISITS
Maternity & Newborn (*)	7,346	10,484
Medical & Surgical	5,276	37,928
Health Instruction		14,368
Infant		7,629
Other Visits (**)		
<b>TOTAL</b>	<b>12,622</b>	<b>69,409</b>

(\*) Newborn: age 28 days or less. Visits include 6,870 for health instruction

(\*\*) Patients not seen. On behalf of patient.

Source: Victorian Order of Nurses for Canada, March Statistics 1960

from data compiled by the Dominion Bureau

of Statistics on cases dismissed by the Victorian Order

in Nova Scotia in 1960, information is available

regarding the age groups of the patients receiving

care and the cause and duration of illness. Table

II shows that patients with medical or surgical

conditions numbered 5,276 and received 41,368 visits.

Services were given for an average period of one day

or extended over several years. The majority of

these patients (59.4 per cent) received care for

less than one month. However, 50 per cent of the

visits were to patients who received care for more

than one year.



TABLE II

NUMBER OF DISMISSED CASES AND VISITS BY  
DURATION OF NURSING SERVICE

<u>Duration of Nursing Service</u>	<u>Cases</u>		<u>Visits</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
Under 1 month	1,753	59.4	5,610	13.6
1 month to 3 mos.	591	20.0	4,432	10.7
3 months to 1 year	466	15.8	10,613	25.7
1 year and over	142	4.8	20,671	50.0
TOTAL	2,952	100	41,326	100

Source: Dominion Bureau of Statistics from Medical and Surgical cases dismissed by the Victorian Order of Nurses for Canada in 1960.

Of the patients dismissed in 1960, 29.5 per cent had received care in hospital before being referred to the Victorian Order of Nurses. 48.1 per cent of the total medical and surgical visits were made to these patients.

The age of patients dismissed from Victorian Order care indicates that 71 per cent of all medical and surgical patients were equally divided between those who were under 15 years of age and those over 65. The majority of visits were made to the older age group and accounted for 61.8 per cent. Table III gives this information.



PAGE II

NUMBER OF DISMISSED CASES AND VISITS BY

DURATION OF NURSING SERVICE

Duration of Nursing Service		Cases		Visits	
Number	%	Number	%	Number	%
Under 1 month	1,753	59.4	5,610	13.6	
1 month to 3 mos.	501	20.0	4,453	10.7	
3 months to 1 year	466	15.8	10,613	25.7	
1 year and over	142	4.8	20,671	50.0	
TOTAL		2,952	100	41,356	100

Source: Dominion Bureau of Statistics from Medical and Surgical cases dismissed by the Victorian Order of Nurses for Canada in 1960.

Of the patients dismissed in 1960, 29.5 per

cent had received care in hospital before being

referred to the Victorian Order of Nurses. 15.1 per

cent of the total medical and surgical visits were

The age of patients dismissed from Victorian

Order care indicates that 71 per cent of all medical and

surgical patients were equally divided between those

who were under 15 years of age and those over 65. The

majority of visits were made to the older age group and

accounted for 61.8 per cent. Table III gives this

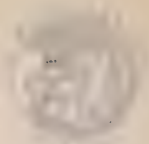
TABLE III

DISTRIBUTION OF MEDICAL AND SURGICAL CASES  
 AND VISITS BY AGE

Age	Cases		Visits	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
Under 15 years	1,042	35.3	4,850	11.7
15 - 44	448	15.2	3,836	9.3
45 - 64	408	13.8	7,105	17.2
65 and over	1,054	35.7	25,535	61.8
<hr/>				
TOTAL	2,952	100.	41,326	100.

Source: Dominion Bureau of Statistics from medical and surgical cases dismissed by the Victorian Order of Nurses for Canada in 1960.

The cause of illness has been classified by 25 cause groups in accordance with the standard groupings listed in the International Classification of Diseases, Injuries and Deaths (1935 Revision). Eight cause groups usually considered to be chronic in nature accounted for 1,079 cases or 36.5 per cent of all medical and surgical patients and for 29,494 visits or 71 per cent of all visits. These cause groups are outlined in Table IV on the following page. The table also shows that 74 patients in these 8 cause groups had care for more than a year and received 15,848 or 38 per cent of the visits to all medical and surgical patients.



# DISTRIBUTION OF MEDICAL AND SURGICAL CASES

## AND VISITS BY AGE

Age		Cases		Visits	
		Number	%	Number	%
Under 15 years		1,042	32.3	4,620	11.7
15 - 64		408	13.8	7,108	17.9
65 and over		1,074	35.7	22,552	61.8
TOTAL		2,524	100.	44,280	100.

Source: Dominion Bureau of Statistics from medical and surgical cases classified by the Victorian Order of Nurses for Canada in 1960.

The cause of illness has been classified by

22 cause groups in accordance with the standard groupings listed in the International Classification of Diseases, Tenth Revision (1959 revision). Eight cause groups usually considered to be amenable to surgery accounted for 1,074 cases or 35.7 per cent of all medical and surgical patients and for 22,494 visits or 71 per cent of all visits. These cause groups are outlined in Table IV on the following page. The table also shows that 74 patients in these 8 cause groups had care for more than a year and received 1,848 or 34 per cent of the visits to all medical and surgical patients.





NUMBER OF CASES AND VISITS BY CAUSES OF ILLNESS (CHRONIC) AND DURATION OF NURSING SERVICE - 1960

TABLE IV

CAUSES	Under 1 month		1 Month & under 1 Year		1 Year & under 2		2 Years & under 3		3 Years & over		Total	
	Cases	Visits	Cases	Visits	Cases	Visits	Cases	Visits	Cases	Visits	Cases	Visits
All causes	1,853	4,610	1,057	15,045	96	10,096	24	3,949	21	6,626	2,951	41,326
Malignant Neoplasm	53	368	58	1,707	5	489	-	-	-	-	116	2,564
Diabetes	33	168	32	1,615	7	1,571	3	1,584	4	2,381	79	7,319
Anemias	26	101	52	751	6	343	4	409	5	1,084	93	2,688
Central Nervous System	135	473	53	1,759	8	3,104	1	22	-	-	294	8,188
Disease of Heart	40	98	47	1,010	5	1,220	-	-	1	202	93	2,530
Other Diseases of Circulatory System	30	126	27	733	4	257	1	167	2	474	64	1,757
Arthritis and Rheumatism	17	73	19	355	4	918	1	59	1	319	42	1,724
Senility symptoms, ill-defined conditions	196	577	90	902	7	593	3	351	2	301	293	2,724
TOTAL	530	1,984	378	8,832	46	8,495	13	2,592	15	4,761	1,079	29,494

Source: Dominion Bureau of Statistics from medical and surgical cases dismissed by the Victorian Order of Nurses for Canada in 1960.





APPENDIX II

1. SUMMARY OF GENERAL RECEIPTS FOR THE YEAR 1960  
IN NOVA SCOTIA

NURSING FEES

Patients	\$36,978
Other (*)	1,307

GRANTS

Municipal	33,719
Provincial	12,300
Other (**)	5,265

COMMUNITY APPEALS

Community Chest	58,190
Branch Campaigns	23,413

OCCUPATIONAL HEALTH SERVICE 24

INCOME FROM SECURITIES AND  
INVESTMENT 5,980

MISCELLANEOUS

Donations, gifts, etc. 8,726

TRANSFERRED FROM SPECIAL  
ACCOUNTS 1,163

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TOTAL RECEIPTS L\*%,)¢%

(\*) 'Other' includes payment from contracts with  
Department of Veterans' Affairs

(\*\*) 'Other' includes grants from school boards,  
cancer clinic.







2. SUMMARY OF GENERAL DISBURSEMENTS FOR THE YEAR  
1960 IN NOVA SCOTIA

Salaries (before tax and other  
deductions)

Nursing Staff	\$139,971
Other	4,238
Transportation Expense	11,705
Rent and Related Expenses	3,098
Nursing Supplies and Equipment	1,207
Office Expenses (*)	3,714
General Expenses (**)	12,051
Miscellaneous Expenses	213
Sundry (unspecified)	216

Capital Disbursements:

Automobile purchase payments	4,070
Furniture & Office Equipment	219
Transferred to Car Depreciation Reserve Account	1,950
Loans repaid; bonds purchased; transfers to other special accounts	<u>100</u>

TOTAL DISBURSEMENTS \$182,752

(\*) Among items included under office expenses are the following: Express; Inspection and Repair; Office Equipment; Nursing forms and records; postage, printing and stationery; telephone and telegraph (including answering service).

(\*\*) Among items included under General Expenses are the following: Advertising and publicity; annual meeting expenses; auditing; bank charges and exchange; dues and subscriptions; insurance - staff accident, sickness - Employers' Liability, Workmen's Compensation, etc.; Laundry, National Professional Service Charge; Nurses Health Examinations; post office safety deposit boxes; refresher courses; pension plan - branch contributions; uniform allowance.



U.S. DEPARTMENT OF COMMERCE  
BUREAU OF ECONOMIC RESEARCH  
1965 IN NOVA SCOTIA

Salaries (before tax and other deductions)

11,700	Transportation Expenses
3,000	Heat and Related Expenses
1,000	Maintaining Supplies and Equipment
3,700	Office Expenses (*)
12,000	General Expenses (**)
210	Miscellaneous Expenses
210	Sundry (unspecified)
4,000	Automobile purchase payments
	Transferred to car depreciation
	House repair; bonds purchased; transfers to other special accounts
\$128,700	TOTAL DISBURSEMENTS

(\*) Among items included under General Expenses are the following: Advertising and publicity; annual meeting expenses; auditing; bank charges and exchange; dues and subscription; insurance; rent; accident, sickness - hospital, liability; for men's compensation, etc.; laundry, national professional service charges; various health examinations, post office salary deposit boxes; telephone calls; post office - business and relations; uniform allowances.

(\*\*) Among items included under General Expenses are the following: Advertising and publicity; annual meeting expenses; auditing; bank charges and exchange; dues and subscription; insurance; rent; accident, sickness - hospital, liability; for men's compensation, etc.; laundry, national professional service charges; various health examinations, post office salary deposit boxes; telephone calls; post office - business and relations; uniform allowances.





1 THE CHAIRMAN: Thank you very much.

2 COMMISSIONER BALTZAN: I don't know whether  
3 it is in the Terms of Reference at all, and you can call  
4 me to order, Mr. Chairman. I must say that this is  
5 probably a public concession, but I do love the Victorian  
6 Order of Nurses more than anybody else does. Not more  
7 than any other nurses, but more than anybody does. I  
8 hear in relation to the progressive care program that is  
9 now being considered and studied, proceeding with other  
10 things, you remember you have only the one function in  
11 home care. If more of you were available, this new aspect  
12 of carrying on work outside the hospital, that factor would  
13 be extended.

14 MRS. REID: It is our desire that it would  
15 be extended. There are many factors that would have to  
16 be considered. For instance, if we were to cover more  
17 area in Nova Scotia, we would have to feel that the need  
18 is there for the nursing service. We would have to also  
19 have the community feeling and financial support from  
20 that area to help us extend our services.

21 COMMISSIONER BALTZAN: How do you feel about  
22 the personnel, and the availability of people on your  
23 staff. Are they easily obtainable?

24 MRS. REID: At the present time, Mr. Chair-  
25 man, I feel that we would have to co-operate very closely  
26 with the public health nursing services before this expan-  
27 sion were undertaken. It is difficult to say that we  
28 would have that many nurses available, because the nursing  
29 situation is quite difficult to obtain, but if the need  
30 was there and we could co-operate with the Public Health

COMMISSIONER BATHMAN: I don't know whether

it is in the line of reference at all, and you can call

me to order, Mr. Chairman. I wish to say that this is

probably a public question, but I do have the Victorian

Order of Nurses more than anybody else does. Not more

than any other nurse, but more than anybody does. I

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now being considered and carried, proceeding with other

things, you remember you have only the one function in

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situation is quite difficult to obtain, but if the need

was there and we could co-operate with the Public Health





1 Department and their nursing service, their nurses, I  
2 think that this could be considered. Probably Miss Wall,  
3 the Regional Director, could speak to that.

4 MISS WALL: At the present moment we haven't  
5 any shortage of staff in Nova Scotia. All our various  
6 existing branches have their full quota of staff. With  
7 the system of bursaries, we have been able to supply the  
8 needs of our branches at the moment. I think in our  
9 brief it is mentioned that we have a frequent turnover of  
10 staff, probably due to the salary scale, and the smaller  
11 areas that are covered in some of our branches. The social  
12 aspects of the area, I think, deter some of the staff from  
13 remaining over a longer period of time. Whether we would  
14 be able to obtain staff to enlarge on the present branches  
15 would need some consideration. Our branches have extended  
16 to a certain extent in the last year or so, and new  
17 branches opened. I think we would have to consider what  
18 the need for nursing care would be, and what service  
19 would be undertaken in an extension, and how much the  
20 requirements would be. This would be, as Mrs. Reid  
21 mentioned, studied with the existing agencies that are in  
22 the community, in co-operation with the local Department  
23 of Health.

24 COMMISSIONER BALTZAN: Essentially, you  
25 depend on your sources, on the availability of registered  
26 nurses generally?

27 MISS WALL: Yes, all our staff in Nova  
28 Scotia are registered nurses. 20 of our staff have public  
29 health training. It is our desire to have all staff with  
30 public health training. At the moment, the proportion is





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 2 think that this could be considered. Probably Miss Wall,  
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 21 mentioned, studied with the existing agencies that are in  
 22 the country, in co-operation with the local Department  
 23 of Health.

24 COMMISSIONER BARTON: Essentially, you

25 depend on your source, on the availability of registered  
 26 nurses generally?

27 MISS WALL: Yes, all our staff in Nova

28 Scotia are registered nurses. 30 of our staff have public  
 29 health training. It is our desire to have all staff with  
 30 public health training. At the moment, the proportion is



1 20 nurses.

2 COMMISSIONER GIRARD: Miss Wall, in line  
3 with the policy of the Order, which is to experiment in  
4 the provision of new service, I know that you are experi-  
5 menting at the present time in a liaison program with  
6 Victoria General Hospital, and you do mention that one of  
7 the advantages is more continuity of nursing care. Could  
8 you tell us if you found other advantages in this liaison  
9 program with the Victoria General Hospital?

10 MISS WALL: Mr. Chairman, I think the liai-  
11 son program with the Victoria General is more or less in  
12 its experimental stages. It was just started in the  
13 Spring, but we have found that as well as a continuity of  
14 service to the patient, that some of the patients would  
15 have been referred, the doctors have been more aware, I  
16 think, of the service being able to continue, or at least  
17 their orders, their treatment, being able to be continued  
18 into the home. I think the fact that the Victorian Order  
19 nurse is seen in the hospital and is available is a good  
20 publicity, and brings the service more to the attention  
21 of the hospital personnel. It has also helped, I think,  
22 in the referral of patients to our other branches, as well  
23 as the Halifax branch, and in getting a written referral  
24 to the nurse in charge of the other communities when the  
25 patient is going home to the smaller areas.

26 COMMISSIONER GIRARD: Do you know if in your  
27 knowledge have any of those patients left the hospital  
28 earlier because of the doctor knew that the V.O.N. would  
29 be looking after the patient in the home? Has it been  
30 instrumental in earlier discharge of patients from the

1 20 years.

2 COMMISSIONER CHAIRMAN: Miss Wall, in line

3 with the policy of the Order, which is to experiment in

4 the provision of new services, I know that you are experi-

5 menting at the present time in a liaison program with

6 Victoria General Hospital, and you do mention that one of

7 the advantages is more continuity of nursing care. Would

8 you tell us if you found other advantages in this liaison

9 program with the Victoria General Hospital?

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12 its experimental stages. It was just started in the

13 Spring, but we have found that as well as a continuity of

14 service to the patient, that some of the patients would

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16 think, of the service being able to continue, or at least

17 their orders, their treatment, being able to be continued

18 into the home. I think the fact that the Victorian Order

19 nurse is near in the hospital and is available is a good

20 publicity, and brings the service more to the attention

21 of the hospital personnel. It has also helped, I think,

22 in the referral of patients to our other branches, as well

23 as the mailfax branch, and in getting a written referral

24 to the nurse in charge of the other communities when the

25 patient is going home to the smaller areas.

26 COMMISSIONER CHAIRMAN: Do you know if in your

27 knowledge have any of those patients left the hospital

28 under the care of the doctor now that the V.C.N. would

29 be looking after the patient in the home? Has it been





1 hospital?

2 MISS WALL: I think it is a little bit too  
3 soon to have any conclusive evidence. I only know that in  
4 visiting with the nurse who is doing this program in the  
5 hospital, she made reference to two or three patients  
6 who were able to go home because the doctor was aware that  
7 they would be able to continue their treatment in the  
8 home.

9 COMMISSIONER GIRARD: One more question.  
10 Through the 15 branches in Nova Scotia you reach 38% of  
11 the population. Do you feel that this is a high percen-  
12 tage, or a low percentage, or would you like to see it  
13 higher in comparison with some other Provinces, to the  
14 percentages that are reached in other Provinces?

15 MISS WALL: I think it is a low percentage.  
16 Or perhaps I should not say low, we would like to see it  
17 extended to a higher percentage, and I think that the fact  
18 that we have in the last few months been extending some  
19 of our branches to include surrounding areas shows that  
20 we are endeavouring to expand. That we are getting  
21 requests for service beyond the boundaries of the branches  
22 that are extended. As mentioned in the brief, just  
23 recently, within the last year, we have made visits to  
24 four communities, three communities that have been reques-  
25 ting service. For the organized branch to extend service  
26 there must be a need for service and an interest in that  
27 community, and a way of supporting the service, and finan-  
28 cial support is one of the difficulties I think in extending  
29 the service, but judging from the requests that we have had  
30 in the last year I think there is a need in some areas to





1 expand in Nova Scotia.

2 THE CHAIRMAN: Mrs. Reid, and perhaps this  
3 question might have been better addressed to Miss Leask.  
4 In the submission which will be forthcoming on the  
5 national level, have you in mind dealing with this proposi-  
6 tion, that is, the place of a voluntary organization such  
7 as the V.O.N. in any comprehensive medical service program?  
8 That is, what is the future of a voluntary organization  
9 in medical health service?

10 MISS LEASK: I think this is a very impor-  
11 tant question that is facing us today, and certainly our  
12 voluntary organization, and I would that it is something  
13 that we are giving, and will be giving, serious considera-  
14 tion to.

15 THE CHAIRMAN: I would like, on behalf of  
16 the Commission, to invite you to come forward with your  
17 considered views on that subject.

18 MISS LEASK: Yes.

19 COMMISSIONER FIRESTONE: Mrs. Reid, the  
20 Victorian Order of Nurses has a very distinguished record  
21 of service. You have done a good job in Nova Scotia, and  
22 you are trying to do a better job. You are saying on  
23 page 7 in the third paragraph that the Victorian Order  
24 service might be used more extensively to relieve the  
25 present strain on hospital facilities, and in the subsequent  
26 paragraph you suggest that one of the reasons this is not  
27 being done is the lack of financial support in organizing  
28 new branches and providing an extension of services. Has  
29 your Nova Scotia chapter given any thought to what would  
30 be required financially to provide this additional service,



1 expand in Nova Scotia,

2 THE CHAIRMAN: Mrs. Held, and perhaps this

3 question might have been better addressed to Miss Leach.

4 In the submission which will be forthcoming on the

5 national level, have you in mind dealing with this proposal

6 tion, that is, the place of a voluntary organization such

7 as the V.O.N. in any comprehensive medical service program?

8 That is, what is the future of a voluntary organization

9 in medical health services?

10 MISS LEACH: I think this is a very impor-

11 tant question that is facing us today, and certainly our

12 voluntary organization, and I would like to do something

13 that we are giving, and will be giving, serious considera-

14 THE CHAIRMAN: I would like, on behalf of

15 the Commission to invite you to come forward with your

16 considered views on that subject.

17 COMMISSIONER BARNSTON: Mrs. Held, the

18 Victorian Order of Nurses has a very distinguished record

19 of service. You have done a good job in Nova Scotia, and

20 you are trying to do a better job. You are saying on

21 page 7 in the third paragraph that the Victorian Order

22 service might be used more extensively to relieve the

23 present strain on hospital facilities, and in the subsection

24 paragraph you suggest that one of the reasons this is not

25 being done is the lack of financial support in organizing

26 new branches and providing an expansion of services. Has

27

28



1 and if the figures are not readily available, could this  
2 information be made available to the Commission at a  
3 later date, indicating also where, in your opinion, these  
4 funds should come from?

5 MRS. REID: Yes, I think we could do that  
6 very easily. Of course, the patients from the hospital  
7 that would be, there may be a possibility it would come  
8 from the hospital insurance, but there again patients  
9 who are not in the hospital and need nursing service, we  
10 are not prepared to say that we only need money to pay  
11 for that service to those people.

12 COMMISSIONER FIRESTONE: Would you be  
13 prepared to give us your views as to what the requirements  
14 are, how much it would cost, and where, in your opinion,  
15 those funds should come from?

16 MRS. REID: Yes, I think we could certainly  
17 figure out what it would cost.

18 COMMISSIONER FIRESTONE: Well, also presumably  
19 things you would recommend for the Province of Nova Scotia?

20 MRS. REID: Yes.

21 COMMISSIONER STRACHAN: Does the Order  
22 frequently find that drug therapy is a burden to your  
23 patients after they have been discharged from hospital,  
24 financially?

25 MISS WALL: It is one of the problems that  
26 we seem to be running into a little bit more since hospi-  
27 tal insurance came into being. We have a feeling, and we  
28 have had patients express their feelings to us, that  
29 drugs are paid for in the hospital, care is paid for in  
30 the hospital, but if they come home and have extension



and if the finances are not readily available, could this

3 later date, indicating also where, in your opinion, there

4 that would be, there may be a possibility it would come

5 very easily. Of course, the patients from the hospital

6 that would be, there may be a possibility it would come

7 from the hospital insurance, but there again patients

8 who are not in the hospital and need nursing services, we

9 are not prepared to say that we only need money to pay

10 for that service to those people.

11 COMMISSIONER KIRKSTONE: Would you be

12 prepared to give us your views as to what the requirements

13 are, how much it would cost, and where, in your opinion,

14 those funds should come from?

15 MRS. WILD: Yes, I think we could certainly

16 figure out what it would cost.

17 things you would recommend for the Province of Nova Scotia?

18 COMMISSIONER STRACHAN: Does the Order

19 frequently find that drug therapy is a burden to your

20 patients after they have been discharged from hospital,

21 MRS. WILD: It is one of the problems that

22 we seem to be running into a little bit more since hospi-

23 tal insurance came into being. We have a feeling, and we

24 have had patients express their feelings to us, that

25 drugs are paid for in the hospital, care is paid for in

26 the hospital, but if they come home and have extension





1 care in the home they must pay the Victorian Order for  
2 the nursing service and they must supply their own drugs.

3 COMMISSIONER STRACHAN: You are finding  
4 that more frequently?

5 MISS WALL: We have no statistics to go by,  
6 but I think we feel that it is more frequent now. There  
7 are of course the patients too who are not in hospital,  
8 who find that it is a burden to obtain some drugs as well,  
9 some of the more expensive drugs.

10 COMMISSIONER BALTZAN: It would seem almost  
11 that the opposite would be true, if the hospital benefits  
12 are real benefits and the cost isn't so great, that they  
13 have greater and more opportunity and more to spare for  
14 these drugs that they had to pay for, for hospitalization,  
15 cost of hospitalization. Why do you notice it a little  
16 bit more since the hospitalization?

17 MISS WALL: I think it is just human nature.  
18 People feel that, they talk of hospital insurance as being  
19 free, and yet they must pay directly for services in the  
20 home.

21 THE CHAIRMAN: Thank you very much, the  
22 ladies from the V.O.N.

23  
24 --- EXHIBIT NO. 11: Submission of the Victorian Order  
25 of Nurses for Nova Scotia.

26  
27 THE CHAIRMAN: The Nova Scotia Division of  
28 the Canadian Cancer Society.

29 THE SECRETARY: This submission will be  
30 Exhibit No. 12.





1 --- EXHIBIT NO. 12: Submission of the Nova Scotia Division  
2 of the Canadian Cancer Society.

3  
4 SUBMISSION OF THE NOVA SCOTIA DIVISION OF THE  
5 CANADIAN CANCER SOCIETY

6 Appearances: Mr. Keith Lawton, President  
7 Dr. Margaret E.B. Gosse, Chairman of  
8 the Provincial Welfare Committee for the  
9 Nova Scotia Division of the Canadian  
10 Cancer Society  
11 Miss Elizabeth A. Hartling, Executive  
12 Secretary

13 MR.LAWTON: Mr. Chairman, members of the  
14 Commission: I was not expected to be here today. My name  
15 is Keith Lawton and I am President of the Nova Scotia  
16 Division of the Canadian Cancer Society. Our brief will  
17 be presented by Dr. Margaret Gosse, who is Chairman of  
18 the Provincial Welfare Committee for Nova Scotia Division  
19 of the Canadian Cancer Society. Also here with us is Miss  
20 Elizabeth Hartling who is the Executive Secretary of the  
21 Nova Scotia Division.

22 Dr. Gosse will be presenting our brief.

23 THE CHAIRMAN: Thank you.  
24  
25  
26  
27  
28  
29  
30







SUBMISSION OF  
CANADIAN CANCER SOCIETY  
NOVA SCOTIA DIVISION

Appearances:

Margaret E. B. Gosse, B.A., M.D., C.M.  
Chairman, Provincial Welfare Committee

The Nova Scotia Division of the Canadian Cancer Society is one of the ten provincial divisions of that Society which was first established by Letters Patent in March 1938 as the Canadian Society for the Control of Cancer and later by supplementary Letters Patent in January 1946 as the Canadian Cancer Society.

It is understood that the Canadian Cancer Society itself proposes to present a brief but since the provincial divisions enjoy a large measure of autonomy in dealing with provincial matters and since, as has been so often reiterated, health is a provincial affair, the Board of Directors of the Nova Scotia Division at a regularly called meeting held on October 3, 1961, decided to submit a brief covering all phases of its interest in cancer and cancer patients within the provincial field.

In the Rules and Regulations governing the Nova Scotia Division of the Canadian Cancer Society its objects are defined as follows:

- (a) To aid in coordinating and correlating the efforts of individuals and organized bodies to reduce the mortality from cancer in Canada.



Appendix

Chairman, Provincial Welfare Committee

The Nova Scotia Division of the Canadian Cancer Society is one of the ten provincial divisions of that Society which was first established by letters Patent in March 1938 as the Canadian Society for the Control of Cancer and later by supplementary letters Patent in January 1945 as the Canadian Cancer Society.

It is understood that the Canadian Cancer Society itself proposes to present a brief but since the provincial divisions enjoy a large measure of autonomy in dealing with provincial matters and since as has been so often reiterated, health is a provincial

affair, the Board of Directors of the Nova Scotia Division at a regularly called meeting held on October 3, 1961, decided to submit a brief covering all phases of its interest in cancer and cancer patients within the provincial field.

In the Rules and Regulations governing the Nova Scotia Division of the Canadian Cancer Society its objects are defined as follows:

(a) To aid in coordinating and correlating the efforts of individuals and organized

bodies to reduce the mortality from cancer





(b) To disseminate knowledge on the subject  
of cancer.

(c) To aid in establishing and maintaining or  
to establish and maintain research  
activities in the fields of cancer.

(d) To obtain money by way of public appeal  
or otherwise and to receive gifts, bequests  
and donations of property, both real and  
personal.

(e) To make grants to, lend money to or guarantee  
the contracts of, or otherwise assist any  
corporations, societies, associations,  
partnerships or individuals who are engaged  
in activities which may be usefully carried  
on in conjunction with the activity of the  
Society and/or which may provide aid to  
the Society in the attainment of its objects.

(f) To assist financially and otherwise in the  
care of patients suffering from cancer.

It appears, therefore, that the potential  
scope of the Society is wide indeed. Essentially its  
actively conducted and independently financed  
programme is covered by clauses b, c, d and f, namely  
cancer education, support of research, patient  
services and fund raising to support these three.

In addition the Society acts in accordance  
with clause (a) by interesting itself in all aspects  
of the struggle against cancer, whether undertaken  
by governments, hospitals, universities, doctors,  
nurses or laymen. Since the Nova Scotia Division



(c) To disseminate knowledge on the subject of cancer.

To aid in carrying out and maintaining or to establish and maintain research activities in the field of cancer.

(d) To obtain money by way of public appeal or otherwise and to receive gifts, deposits and donations of property, both real and personal.

(e) To make grants to and money to or guarantee

corporations, societies, associations, partnerships or individuals who are engaged in activities which may be usefully carried on in cooperation with the activity of the Society and/or which may provide aid to the Society in the attainment of its objects.

(f) To assist financially and otherwise in the care of patients suffering from cancer.

It appears, therefore, that the potential scope of the Society is wide indeed. Essentially the Society is engaged in the following activities: (a) research, (b) education, (c) public relations, (d) financial support, (e) medical services and (f) raising funds to support these three.

In addition the Society acts in accordance with clause (c) of its objects in all aspects of the struggle against cancer, whether undertaken by governments, hospitals, universities, doctors, nurses or laymen. Since the Nova Scotia Division



1 established it has continued to seek advances in  
2 the care and treatment of cancer patients and has  
3 from time to time petitioned the provincial govern-  
4 ment on behalf of the following:

5 1948 - February - Transportation to diag-  
6 nosis and treatment at provincial centre. Establish-  
7 ment of a Cancer Clinic at that centre. Facilities  
8 for the care of terminal cases.

9 1948 - November - Facilities for the care  
10 of chronic cases.

11 1952 - That the Federal Health Grant  
12 for Cancer be utilized to set up diagnostic and  
13 treatment centre for province.

14 1954 - That a cobalt unit be procured.

15 1954 - That free transportation to diagnosis  
16 and treatment be provided and that a hostel  
17 be established to house patients utilizing  
18 such a plan.

19 1956 - A hostel for ambulatory patients.

20 1959 - Some provision for such patients -  
21 a boarding home in lieu of a hostel.

22 Out of all this list the following have  
23 come into being due, at least in part, to the  
24 Society's interest:

25 1. The Nova Scotia Tumour Clinic for the  
26 Diagnosis and Treatment of Cancer, established  
27 in March 1953 in connection with the govern-  
28 ment operated Victoria General Hospital in  
29 Halifax.

30 2. Free transportation to and from this clinic





...the ... of ...

the care and treatment of cancer patients and from

from time to time petitioned the provincial govern-

ment on behalf of the following:

1946 - February - Transportation to diag-

nosis and treatment at provincial centres. Hospital-

ment of a cancer victim at that centre. Hospital-

for the care of terminal cases.

1948 - November - Facilities for the care

of chronic cases.

1952 - That the Medical Health Board

for Cancer be utilized to act as diagnostic and

treatment centre for patients.

1954 - That a cabinet committee be formed.

1954 - That the transportation to diagnostic

and treatment be provided and that a hospital

be established to house patients awaiting

such a plan.

1955 - A hostel for ambulatory patients.

1956 - Some provision for such patients -

a building, some in form of a hostel.

Out of all this list the following have

come into being and, at least in part, to the

provincial interest:

1. The Nova Scotia Cancer Council for the

diagnosis and treatment of cancer, established

in March 1953 in connection with the govern-

ment sponsored Victoria General Hospital in

Halifax.

2. The transportation to and from the



1 to all with income under \$3,500 financed  
2 by provincial government, administered by  
3 the Cancer Society.

- 4 3. Installation of Cobalt Therapy Unit in the  
5 Victoria General Hospital.

6 Thus far no success has been achieved in the  
7 effort to secure planned facilities for terminal,  
8 chronic or ambulatory patients.

9 In the light of this continued and active  
10 interest in all that concerns cancer and cancer  
11 patients the Society naturally wishes to avail itself  
12 of the opportunity to make known its views as to pre-  
13 sent and future needs in this field.

14 For the sake of brevity and clarity our  
15 material will be presented under five main headings,  
16 as follows:

- 17 1. Prevention or Education  
18 2. Diagnosis and Treatment in general  
19 3. Treatment and Rehabilitation  
20 Patient Services by the Cancer Society  
21 4. Physical Facilities  
22 5. Research

23 In consideration of these various matters  
24 we will be touching upon clauses (a), (b), (f), (j)  
25 and (k) of the terms of reference of the Royal  
26 Commission on Health Services.

27 1. Prevention or Education - must in cancer be inter-  
28 preted rather as effort towards early diagnosis, since  
29 with a few minor (and one major) exceptions, no known  
30 specific preventive means exist.



to all with income under \$1,000 provided  
by provincial government, administered by  
the Public Health Service.

3. Institute of Cancer Therapy Unit in the  
Victoria General Hospital

Thus far no success has been achieved in the  
effort to secure planned facilities for terminal,  
chronic or ambulatory patients.  
In the light of this continued and active

interest in all their concerns cancer and cancer  
patients the Society naturally wishes to avail itself  
of the opportunity to make known the views as to pre-  
sent and future needs in this field.

For the sake of brevity and clarity our  
material will be presented under five main headings,  
as follows:

1. Prevention or Mitigation
2. Stages and Treatment in General
3. Treatment and Rehabilitation  
Facilities provided by the Cancer Society
4. Physical Facilities
5. Research

In consideration of these various matters  
we will be touching upon cancer (a), (b), (c), (d)  
and (e) of the terms of reference of the Royal  
Commission on Cancer Research

1. Prevention or Mitigation - must in some way be intro-  
duced rather as a part towards early diagnosis, since  
with a new tumor (and its major) and often, no longer  
specific preventive means exist.





(A) Lay Education - At present by Cancer Society by

1. Pamphlets
2. Films
3. Mass Media
4. Lectures, etc.

Cost \$20,000 annually from voluntary contributions.

Improvement -

Expert planning

Comprehensive coverage

Most effective means and methods.

Greatly increased cost.

This seems to be a field in which the Cancer Society can work effectively. How to find additional money is a problem. Discontinuing other services would release some but not enough.

(B) Professional Education (Other than post graduate training).

At Present: by Cancer Society by small travel grants (inadequate) and other sources, uncertain and inadequate.

Improvement: Extended opportunities to visit centres and attend meetings, conferences and short courses.

Financing: Cancer Society cannot assume but might co-operate in coordinated plan by

1. Government
2. Medical School
3. Hospitals
4. Medical Society



(1) Lay Education - At present by General Society by

1. Teachers

2. Nurses

3. Social Workers

4. Technicians, etc.

Cost \$2,000 annually from voluntary contributions.

Improvement -

Expert planning

Comprehensive coverage

Very good results

There seems to be a field in which the work

Society can work effectively. How to find additional

money is a problem. Discontinuing other services

would release some but not enough.

(D) Professional Education (Other than post graduate

training).

At present General Society by small travel grants

(Indirectly) and other sources, uncertain

and inadequate.

Improvement: Exchanged opportunities to visit centers

and attend meetings, conferences and short

courses.

Financing: General Society cannot assume but might co-

operate in coordinated plan by

1. Medical Council

2. Hospitals

3. Medical Society



1 It is our view that education, both lay  
2 and professional is of the utmost importance. What-  
3 ever diagnostic or treatment facilities may be avail-  
4 able now or in the future, it is certain that to be  
5 effective they must be sought by the patient, and  
6 known and utilized by the physician, EARLY.

7  
8 2. Diagnosis and Treatment in General.

9 Available in Nova Scotia at -

- 10 1. Nova Scotia Tumour Clinic at Victoria  
11 General Hospital in Halifax. Complete  
12 diagnostic and treatment service. National  
13 Hospitalization applies in all hospitals.
- 14 2. Hospitals throughout province. Limited  
15 Services.
- 16 3. Nova Scotia Government Transportation Plan  
17 applies only to Nova Scotia Tumour Clinic.  
18 Confined to those with incomes of \$3,500  
19 or less.

20 It is estimated that about 50 per cent of all  
21 cancer patients in Nova Scotia are known to, and  
22 followed by the Nova Scotia Tumour Clinic. This  
23 follow-up, of such extreme importance in cancer pro-  
24 grammes, is virtually complete. Nevertheless, the  
25 fact remains that half the cancer patients in Nova  
26 Scotia are unregistered and nothing is known of their  
27 treatment or its results. The achievement of a complete  
28 provincial cancer registry lies within easy reach since  
29 the introduction of national hospitalization, and the  
30 Cancer Society, in keeping with its policy of advoca-  
ting advances along every line, joins with other





It is our view that education, both for

and professional is of the utmost importance, what-  
ever diagnostic or treatment facilities may be avail-  
able now or in the future, it is certain that to be  
effective they must be sought by the patient, and  
known and utilized by the physician, early.

## 2. Diagnosis and Treatment in General.

Available in Nova Scotia at -

1. Nova Scotia Tumour Clinic at Victoria  
General Hospital in Halifax. Complete

Hospitalization applies in all hospitals.

3. Nova Scotia Government Transportation Plan  
applies only to Nova Scotia Tumour Clinic.  
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grammes, is virtually complete. Nevertheless, the

fact remains that half the cancer patients in Nova

Scotia are unregistered and nothing is known of their

treatment or its results. The achievement of a complete

provincial cancer registry lies within easy reach since

the interconnection of national hospitalization, and the

Cancer Society, in keeping with its policy of advocacy.



1 groups in urging the early establishment of such a  
2 registry.

3 The Nova Scotia Division of the Cancer  
4 Society administers the Transportation to Treatment  
5 Plan of the Nova Scotia Government. The application  
6 of the means test requires that volunteers in centres  
7 outside of Halifax, as well as administrative staff  
8 in Halifax, must be involved in income investigation,  
9 as well as routine transportation problems. The  
10 removal of the means test might possibly lead to a few  
11 more patients attending the Tumour Clinic but there  
12 would be no significant reduction in work for the  
13 Society. Generally speaking this has been a con-  
14 spicuously successful cooperative effort.

15 3. Treatment and Rehabilitation - Patient Services -  
16 by the Cancer Society.

17 At present the Cancer Society provides:

- 18 1. Free cancer dressings - cost \$10,000 a year.
- 19 2. Pain killing drugs in cases of need and in-  
20 ability to pay.
- 21 3. Assistance in purchase of therapeutic appli-  
22 ances and those necessary for rehabilitation  
23 in cases of need.
- 24 4. Loan Cupboard supplies and sick room needs  
25 other than drugs.
- 26 5. Nursing and housekeeper services in cases of  
27 real need.
- 28 6. Specially prepared pamphlets for post opera-  
29 tive cancer patients with gastro-intestinal  
30 and breast cancer - a small but valuable ser-  
vice.



groups in origin the early establishment of a registry.

The Nova Scotia Division of the Cancer

Society administers the transportation to treatment plan of the Nova Scotia Government. The application of the means test requires that volunteers in need be outside of Halifax, as well as administrative staff to Halifax, must be involved in income investigation, as well as routine transportation problems. The removal of the means test might possibly lead to a few more patients attending the Tumor Clinic but there would be no significant reduction in work for the Society. Generally speaking this has been a considerably successful cooperative effort.

3. Treatment and Rehabilitation - Patient Services - by the Cancer Society.

At present the Cancer Society provides:

1. Free cancer drugs - cost \$10,000 a year.
2. Free living drugs in cases of need and inability to pay.
3. Assistance in purchase of therapeutic appliances and those necessary for rehabilitation in cases of need.
4. Loan cupboard supplies and sick room needs.
5. Housing and household services in cases of need.
6. Speciality prepared hospital for last care - five cancer patients with gastro-intestinal





Improvement - The Society has been willingly involved in Dressing and Loan Cupboard programmes. Other excursions into the fringe areas of treatment have been in response to needs unmet by other means and have involved lay workers often unhappily in medical problems. The view might be advanced that all items which are properly part of treatment should be provided by whatever body undertakes responsibility in this field, either now or at any future time. Where drugs and appliances are concerned we are unreservedly of this opinion. In the case of cancer dressings, admittedly the largest single item in the Society's patient services, the part played by voluntary workers in making and distribution assumes such significance as to economy, efficiency and patient and volunteer morale, that the Cancer Society might not be disposed to surrender this programme in its entirety. Perhaps, however, the release of money for other purposes might be accomplished by the financing of the cost of materials by whatever body undertakes to supply treatment in general. In Nova Scotia the participation by the Society in the Transportation to Treatment Plan is an already existing example of this sort of co-operation by Government and Voluntary Agency.

#### 4. Physical Facilities.

Present -

1. Hospital beds, free under hospital insurance. Inadequate in number and rendered more so by occupancy by ambulatory, post-operative convalescent, chronic and terminal cases. Cancer





1 patients requiring active treatment have  
2 priority but often wait because of lack of  
3 beds.

4 2. A few nursing and convalescent homes, not  
5 available free under hospital insurance.  
6 Cancer Society sometimes pays for care in  
7 these.

8 3. Day accommodation in Cancer Society's waiting  
9 rooms at provincial headquarters in Halifax  
10 for patients attending Nova Scotia Tumour  
11 Clinic.

12 4. Overnight boarding facilities provided,  
13 in special cases, by the Cancer Society for  
14 patients from outside Halifax attending the  
15 Tumour Clinic. On the increase.

16 Needed -

17 1. More hospital beds.

18 2. Provision for terminal care. These patients  
19 should not occupy hospital beds when nothing  
20 can be done for them. They often cannot be  
21 cared for at home. Terminal care should be  
22 available, on a regional basis, so that the  
23 dying need not be cut off from family and  
24 friends. Nursing care required.

25 3. Convalescent post-operative beds in associa-  
26 tion with hospitals and re-education and re-  
27 habilitation services. Nursing care re-  
28 quired.

29 4. Boarding home for ambulatory patients re-  
30 ceiving treatment or in City to attend at





patients requiring active treatment have  
primarily but often with degree of lack of

A few nursing and convalescent homes, not  
available in the local hospital area, and  
other family arrangements may be made in  
these.

Day accommodation in senior hospital waiting  
rooms at provincial headquarters in Halifax  
is available.

Overnight boarding facilities provided,  
in special cases, by the senior hospital for  
patients from outside Halifax attending the  
senior clinic on the hospital.

Home hospital care,  
Provision for terminal care. These patients  
should not occupy hospital beds when waiting  
can be done for them. They often cannot be  
cared for at home. Terminal care should be  
available, on a regional basis, so that the  
dying need not be cut off from family and  
friends. Nursing care required.

Convalescent post-operative beds in associa-  
tion with hospitals and rehabilitation and re-  
habilitation services. Nursing care re-  
quired.

Boarding home for ambulatory patients re-



1 Tumour Clinic. No nursing care required.

2 The Cancer Society regards these needs  
3 as of the utmost urgency. It will be noted that  
4 these facilities in one form or another have been  
5 sought time after time since the Society was formed.

6  
7 5. Research.

8 Past - Before the foundation of the National  
9 Cancer Institute, the Nova Scotia Division supported  
10 research at Dalhousie by small direct grants - mostly  
11 for the purchase of equipment. After the Institute  
12 was set up and the Divisions of the Cancer Society  
13 began to be assessed for money for research, the  
14 local grants were no longer possible, nor were they in  
15 the same way necessary.

16 Present - The Nova Scotia Division of the Canadian  
17 Cancer Society now supports fundamental or basic re-  
18 search through its contributions to the National Cancer  
19 Institute. About one-third of money raised by public  
20 appeal is applied to this - roughly \$30,000. A pro-  
21 portion of this returns to the province in research  
22 grants under the Institute.

23 Needs -

- 24 1. Money to finance clinical research projects,  
25 particularly in connection with the Nova  
26 Scotia Tumour Clinic. The National Cancer  
27 Institute fosters in the main research in  
28 laboratories as opposed to research directly  
29 to do with patients. The Nova Scotia Division  
30 of the Cancer Society receives requests for  
aid in clinical research projects which







1 it is unable to meet because of other com-  
2 mitments. The Nova Scotia Division con-  
3 sidered it desirable that this zeal to  
4 inquire should not go unsatisfied. It con-  
5 sidered that intensified professional education,  
6 coupled with clinical research, would lead  
7 to a keener, more concerted attack on cancer.

8 2. A specific and well-defined research need of  
9 growing urgency is for a chemotherapist to work  
10 on problems of chemotherapy in connection  
11 with the Nova Scotia Tumour Clinic. While  
12 surgery and radiation therapy are by no  
13 means displaced, the newest therapeutic methods  
14 are chemical. To give them an adequate  
15 appraisal is not possible in the absence of  
16 a fully trained chemotherapist.

17 It must have been noted that, while sug-  
18 gestions for improved health services in the fight  
19 against cancer have been freely offered, we have been  
20 reluctant to make definite estimates as to costs or  
21 how they should be borne. In the case of services ren-  
22 dered by the Cancer Society we know what we spend but  
23 not what it would take to do the job as it should be  
24 done. This is true in the field of education par-  
25 ticularly. In other cases it is not within our com-  
26 petence to judge what the cost would be. The Cancer  
27 Society has raised increasing amounts annually over  
28 the years and can probably continue to raise a little  
29 more each year but it will never be able to raise in  
30 Nova Scotia enough to meet the needs it sees. It





1 would be foolish to refuse to recognize our limitations  
2 which imply that we have a sphere of influence as well  
3 as sphere of activity; in the latter we are self-  
4 supporting whereas items falling into the former must  
5 be paid for by other agencies. In the past we have  
6 turned to government and there is no reason to expect  
7 to look elsewhere in the future. What it amounts to  
8 is that if we profess to be concerned about cancer and  
9 want something done about it then we must look to it and  
10 see that one way or another we provide the money to  
11 pay the bill.





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2 which imply that we have a sphere of influence as well  
3 as sphere of activity; in the latter we are safe  
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8 is that if we propose to be concerned about cancer and  
9 want something done about it then we must look to it and  
10 see that one way or another we provide the money to  
11 pay the bill.



1 COMMISSIONER BALTZAN: May I then just say  
2 this. Yours is entirely a voluntary body?

3 DR. GOSSE: Yes.

4 COMMISSIONER BALTZAN: And your means are  
5 entirely from voluntary contributions?

6 DR. GOSSE: The money we spend on our own  
7 program is raised by public subscription in a financing  
8 campaign, yes.

9 COMMISSIONER BALTZAN: And I expect that  
10 the public good, in the good service you give, you would  
11 like to maintain that and continue to work on a public  
12 service voluntary human contribution basis?

13 DR. GOSSE: If I am not mistaken, this is  
14 another aspect. The question has been asked before: what  
15 is to become of the voluntary agencies under future plans?  
16 Our division of the Cancer Society has always visualized  
17 that some day it might go out of business; that is, if  
18 everything we do, results have been achieved or the work  
19 is done by somebody else, we would retire from the field,  
20 with considerable relief, I think. But I am afraid none  
21 of us visualize that happening in the very near future.  
22 There are some phases which seem to be done particularly  
23 well by the voluntary agency, perhaps in the intangible  
24 field, education, and in the tangible field, the cancer  
25 dressing program. We produce them at no cost other than  
26 the cost of materials.

27 COMMISSIONER VAN WART: Do you have a volun-  
28 tary nursing service or do you rely on the V.O.N.?

29 DR. GOSSE: We receive co-operation from  
30 V.O.N. and we appreciate the co-operation. We also use



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14 with considerable relief, I think. But I am afraid none

15 dressing program. We produce them at no cost other than

16 the cost of materials.

COMMISSIONER VAN HART: Do you have a volun-

17 tary material service or do you rely on the V.O.N.?

DR. GOSSE: We receive co-operation from

18 V.O.N. and we appreciate the co-operation.





1 other nursing services when required when it is necessary  
2 to have a nurse staying the house. Sometimes they are  
3 practical nurses. If we had provided you with an extensive  
4 statement you would see that none of these items is very  
5 large.

6 COMMISSIONER FIRESTONE: Dr. Gosse, your  
7 brief suggests that the Nova Scotia Division of the Cancer  
8 Society provides a very helpful service to the people of  
9 Nova Scotia. You indicate that if more funds were available  
10 more could be done, more should be done. You also sugges-  
11 ted that perhaps you could make available to the Commission  
12 more information if you were requested to do so.

13 DR. GOSSE: Yes.

14 COMMISSIONER FIRESTONE: Could we ask you to  
15 tell us what, in the opinion of the Nova Scotia Division  
16 of the Cancer Society, would be a desirable and realistic  
17 program in the field of cancer care, education and research  
18 for the Province of Nova Scotia, what such a program would  
19 cost, capital budget and operating budget for the next  
20 five years, and what the different sectors are contributing  
21 to such capital and operating budget - I am referring to  
22 the private sector and the public sector, and by the public  
23 sector I refer to Provincial and Federal Government.

24 Would you let us have such information at a later date?

25 DR. GOSSE: Mr. Chairman, I feel that we  
26 could produce this information, but we would have some  
27 difficulty in doing it under our own steam. I am sure  
28 we could get the co-operation of other bodies which would  
29 make it possible for us to do it.

30 COMMISSIONER FIRESTONE: Thank you very much,



other nursing services when required when it is necessary  
to have a nurse staying the house. Sometimes they are  
practical nurses. If we had provided you with an extensive  
statement you would see that none of these items is very

brief suggests that the Nova Scotia Division of the Cancer  
Society provides a very helpful service to the people of  
Nova Scotia. You indicate that if more funds were available  
more could be done, more should be done. You also sugges-  
ted that perhaps you could make available to the Commission  
more information if you were requested to do so.

MR. GOSSE: Yes.

COMMISSIONER FIFTHSTONE: Could we ask you to  
tell us what, in the opinion of the Nova Scotia Division  
of the Cancer Society, would be a desirable and realistic  
program in the field of cancer care, education and research  
for the Province of Nova Scotia, what such a program would  
cost, capital budget and operating budget for the next  
five years, and what the different sectors are contributing  
to such capital and operating budget - I am referring to  
the private sector and the public sector, and by the public  
sector I refer to Provincial and Federal Government.

Would you let us have such information at a later date?

MR. GOSSE: Mr. Chairman, I feel that we

could produce this information, but we would have some

difficulty in doing it under our own steam. I am sure

we could get the co-operation of other bodies which would

make it possible for us to do it.



1 Doctor.

2 THE CHAIRMAN: Thank you very much.

3 SUBMISSION OF THE CANADIAN HEALTH

4 INSURANCE ASSOCIATION

5 Appearance: Dr. J.C. Emmett

6  
7 --- EXHIBIT NO. 13: Submission of the Canadian Health  
8 Insurance Association.

9  
10 DR. EMMETT: Mr. Chairman, members of the  
11 Commission, if I may take a moment of your time to identify  
12 myself. My name is Emmett; I am a physician, associated  
13 with the insurance industry, and in the course of my duties  
14 in the last year-and-a-half I have spent some time working  
15 with the Health Insurance Association in the study of  
16 health insurance plans. It is a privilege on their behalf  
17 to present this very brief preliminary statement.

18 1. The Canadian Health Insurance Association,  
19 an organization comprising 117 insurance companies operating  
20 in the health insurance field in Canada, would like at this  
21 time to make a short statement to the Commission in advance  
22 of a more detailed presentation to be made at a later  
23 hearing, and which will describe the Association's plan to  
24 provide voluntary medical care insurance to Canadians  
25 regardless of health, age or occupation.

26 2. The Association, whose member companies  
27 account for more than 96 per cent of all the health insu-  
28 rance companies in Canada, was formed in the belief that  
29 the high quality of medical care now available to most  
30 Canadians can best be maintained and improved for present





1 Doctor.

2 THE CHAIRMAN: Thank you very much.

3

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11 myself. My name is Emmett; I am a physician, associated

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14 with the Health Insurance Association in the study of

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19 in the health insurance field in Canada, would like at this

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26 account for more than 95 per cent of all the health insur-

27 ance companies in Canada, was formed in the belief that

28 the high quality of medical care now available to most

29 Canadians can best be maintained and improved for present



1 and future generations by a continuation of the present  
2 voluntary system, and financing a large part of its cost  
3 through prepaid medical insurance.

4 3. At the present time, some 8 million  
5 Canadians - almost half the population of the country -  
6 are insured in voluntary plans provided by the life,  
7 general and health insurance companies and through volun-  
8 tary plans provided by medical associations.

9 4. The Association firmly believes that  
10 these figures not only reflect the tremendous increase in  
11 the demand for voluntary health insurance in recent years,  
12 but are indicative of the confidence of the public in  
13 existing plans.

14 5. Since its formation two and a half years  
15 ago, our Association has worked diligently to provide and  
16 expand medical care benefits. It is convinced that with  
17 the co-operation of all parties concerned, the present  
18 voluntary plans can be modified and improved to provide  
19 this same high standard of medical care through voluntary  
20 health insurance at a reasonable premium cost to all  
21 Canadians, regardless of age, health or occupation, and  
22 accomplished without involving governments at either the  
23 federal or provincial level in substantial new costs and  
24 extensive new administrative machinery.

25 6. The Association maintains that voluntary  
26 plans of this type protect the free choice of doctor by  
27 the patient and vice versa, and do not in any way interfere  
28 with their relationship with one another. These benefits,  
29 impossible to calculate, would be preserved in any proposed  
30 extension of present voluntary plans to include currently



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2 voluntary system, and financing a large part of its cost  
3 through prepaid medical insurance.

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20 health insurance at a reasonable premium cost to all

21 Canadians, regardless of age, health or occupation, and

22 accomplished without involving governments at either the

23 federal or provincial level in substantial new costs and

24 extensive new administrative machinery.

25 6. The Association maintains that voluntary

26 plans of this type protect the free choice of doctor by

27 the patient and vice versa, and do not in any way interfere

28 with the medical profession's right to practice as they see fit.

29 It is also responsible to emphasize, would be preserved in any proposed

30 extension of present voluntary plans to include currently





1 ineligible groups and individuals. The insurance industry  
2 recognizes that only doctors can provide medical care, and  
3 that the role of insurance companies is only to help  
4 devise the means of financing the cost of such care.

5           7. The Association is very well aware that  
6 some segments of the population are not in a financial  
7 position to pay even a most reasonable premium for volun-  
8 tary medical insurance. Such persons, it feels, will  
9 continue to require financial assistance from the govern-  
10 ments or others; it believes, however, that it is  
11 unrealistic and unnecessary to institute overall, compul-  
12 sory, government-sponsored plans applicable to the entire  
13 population in order to care for this relatively limited  
14 group.

15           8. The Canadian Health Insurance Association  
16 is currently developing a specific program to achieve  
17 these ends, for presentation at a later hearing of this  
18 Commission. Our proposed plan maintains the advantages of  
19 competition which are most essential for the successful  
20 operation, financial or otherwise, of any plan of health  
21 care.

22           9. The Association proposes to offer to  
23 co-operate with the medical associations and medically-  
24 sponsored prepayment plans in developing programs of volun-  
25 tary coverage available to all. Meanwhile, the Association  
26 will continue to offer its facilities and those of its  
27 member companies to assist your Commission in any way you  
28 believe we can be of assistance.

29           THE CHAIRMAN: Thank you, Dr. Emmett.

30           MR. HALL: Mr. Chairman, as this is a



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2 recognizes that only doctors can provide medical care, and

3 that the role of insurance companies is only to help

4 devise the means of financing the cost of such care.

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19 competition which are most essential for the successful

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23 co-operate with the medical associations and medically

24 sponsored programs in developing programs of volun-

25 tary coverage available to all. Meanwhile, the Association

26 will continue to offer its facilities and those of its

27 member companies to assist your Commission in any way you

28 believe we can be of assistance.

Very truly yours,

Mr. Hall, Mr. Chairman, as this is a



1 preliminary submission, I don't think there are any ques-  
2 tions I want to ask, except to state that perhaps there  
3 will be a request for statistical information which will  
4 be best submitted in a written form.

5 DR. EMMETT: Yes.

6 COMMISSIONER BALTZAN: I wish them very  
7 good luck.

8 COMMISSIONER FIRESTONE: Dr. Emmett, you are  
9 familiar with our Terms of Reference?

10 DR. EMMETT: Yes, I am, sir.

11 COMMISSIONER FIRESTONE: Item (h) calls for  
12 the Royal Commission to look into the question of methods  
13 of financing health care services as presently sponsored  
14 by management, labour, professional associations, insurance  
15 companies or in any other manner. We are therefore in the  
16 process of embarking on a survey of pre-paid medical care  
17 plans in Canada. Our research staff is in the process of  
18 developing an outline for such a study and advise the  
19 Commission on the scope of this inquiry. We have been in  
20 touch with the President of your Association, Mr. Reid,  
21 to inquire whether we can have the help of your Association  
22 in commenting on the scope of this inquiry and the items  
23 that might be covered so that we would have the advice of  
24 the industry, and Mr. Reid has indicated he and his  
25 associates would be very glad to co-operate with us. I  
26 take it that you, as the spokesman for the Association,  
27 would concur with this?

28 DR. EMMETT: I certainly would, sir.

29 COMMISSIONER FIRESTONE: Our own research  
30 staff will therefore be in touch with your offices and





1 preliminary submission, I don't think there are any ques-  
2 tions I want to ask, except to state that perhaps there  
3 will be a request for statistical information which will  
4 be best submitted in a written form.

5  
6 DR. HENRY BALLANT: I wish them very

7 good luck.

8 Dr. Bennett, you are

9 familiar with our terms of reference?

10 DR. BENNETT: Yes, I am, sir.

11 Item (H), refers to

12 the Royal Commission to look into the question of methods

13 of providing health care services as presently sponsored

14 by management, labour, professional associations, insurance

15 companies or in any other manner. We are therefore in the

16 process of elaborating on a survey of pre-paid medical care

17 plans in Canada. Our research staff is in the process of

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20 to inquire whether we can have the help of your association

21 in commenting on the scope of this inquiry and the items

22 that might be covered so that we would have the advice of

23 the industry, and Mr. Reid has indicated he and his

24 association would be very glad to co-operate with us. I

25 spoke to him, you, and the spokesman for the Association.

26 We are in touch with them.

27 DR. BENNETT: I certainly would, sir.

28 COMMITTEE: (DR. BENNETT) (DR. BENNETT)

29 I am sure that the Commission will be in touch with you often, and



1 will get help from the member companies as they see fit.

2 DR. EMMETT: We would be very grateful.

3 COMMISSIONER FIRESTONE: Now, to proceed  
4 from here, you are familiar that some of the things that  
5 the insurance industry has been doing in the field of  
6 pre-paid medical care plans have been subject to criticism,  
7 and we are just wondering whether it would be helpful at  
8 this preliminary stage if we would outline to you some of  
9 the areas or items that we would hope you would comment  
10 on in your final submission. Would that be helpful to you?

11 DR. EMMETT: It would be very helpful.

12 COMMISSIONER FIRESTONE: In making some  
13 comments as to possible areas to be covered, this is in  
14 no way an implication that the Commission itself is criti-  
15 cal of the schemes; it is just trying to find an answer to  
16 what the situation is, and therefore I am going to list  
17 them, and you could look at them, and you should not look  
18 at this as an all-inclusive list, and I would assume that  
19 your Association would look at a number of the briefs  
20 submitted to the Commission which contain criticism and  
21 comment and you yourself would pick those items and  
22 comment. Can we take it that you will be doing this?

23 DR. EMMETT: We will, sir.

24 COMMISSIONER FIRESTONE: Perhaps I will  
25 raise certain things that have been contained in the  
26 submissions given to us, and I take it you will have the  
27 record and it will be a guide to yourself and your asso-  
28 ciates.

29 One question that has been raised is as to  
30 how many of those plans are based on insurance covering



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2 DR. EMMETT: We would be very grateful.

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5 the insurance industry has been doing in the field of

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25 submissions given to us, and I take it you will have the

26 record and it will be a guide to yourself and your asso-

27 One question that has been raised is as to

28 how many of these plans are based on insurance covering





1 indemnity and how many cover full services, and we would  
2 like to have some information on that particular point,  
3 the type of coverage. We would like you to advise us also  
4 as to what is covered under indemnity schemes and what is  
5 covered under full services, more or less full services,  
6 because in some instances the services will not be quite  
7 complete.

8 A second point that has been raised is that  
9 medical care plans do not cover preventive medicine. Is  
10 that correct? And if it is, are there any plans afoot  
11 that would deal with problems of preventive medicine on  
12 the basis of the application of the insurance principle?

13 Three, how about the coverage of dental  
14 services?

15 Four, coverage of drugs.

16 Five, coverage of nursing services.

17 Six, coverage of laboratory services.

18 Seven, can you tell us more about dollar  
19 limitation, exclusion of kind of illness, age, sex,  
20 illness, occupation.

21 Eight, what proportion of doctor bills are,  
22 in fact, covered? Do some companies cover 90%, some 45%?  
23 What, in fact, proportion of doctor bills are covered, and  
24 by doctor bills I am not referring to the rate schedule,  
25 I am referring to doctor bills that are rendered by doctors  
26 and which patients have to pay.

27 Nine, can we have your comments on the subject  
28 whether there should be or should not be public control of  
29 such plans, whether the company should be permitted to do  
30 anything they want, whether they pay 40¢ out of the dollar



indemnity and how many cover full services, and we would like to have some information on that particular point, the type of coverage. We would like you to advise us also as to what is covered under indemnity schemes and what is covered under full services, more or less full services, because in some instances the services will not be quite complete.

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Nine, can we have your comments on the subject of self-insurance? Should it be or should not be public control of self-insurance, whether the company should be permitted to be self-insuring or not, whether they pay out of the dollar



1 insured or 90¢ of the dollar.

2 Ten, can you offer some observations on the  
3 question whether the pre-paid medical care plans are  
4 mainly concerned with quantity or also concerned with  
5 quality of the medical service?

6 Eleven, can you tell us something about  
7 cancellations of contract?

8 Twelve, of applications refused and the  
9 reason for it?

10 Thirteen, have you information or can you  
11 supply us with information, as to what proportion of the  
12 dollar received by commercial insurance carriers is paid  
13 back in fees, and I am not looking just for an average  
14 but information of the various companies so that we can  
15 get the range, do they do more than others?

16 Fourteen, can you give us some indication  
17 as to how this insurance dollar is really spent? Of the  
18 portion that doesn't go back to the insured, how that is  
19 spent, in selling expenses, administration expenses, over-  
20 heads, etc.?

21 Fifteen, you say in paragraph 7 that your  
22 Association is not in favour of an overall compulsory  
23 Government-sponsored plan applicable to the entire popula-  
24 tion, and you justify this on the basis that it would take  
25 care only of a rather limited group. Does this not assume  
26 that all other voluntary medical care plans are, in effect,  
27 taking care of everybody? Does it not assume that people  
28 should be satisfied if they get, say, 50¢ out of the  
29 dollar which they have paid in and they have to pay the  
30 other 50¢ of the doctor bills themselves? And if that is







1 the situation, can you explain to the Commission whether  
2 this is a satisfactory state from a national point of  
3 view, and, if this is not your position, can you explain  
4 what your position is?

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1 Sixteen, can you explain to us what you  
2 mean in paragraph 8 of your preliminary submission, when  
3 you speak of the advantages of competition? Can you  
4 spell out those advantages?

5 Seventeen, in paragraph 9 you speak of  
6 developing programs of voluntary coverage available to  
7 all. Does all mean all that can pay for it? And if it  
8 does not, what does it mean? Thank you very much.

9 THE CHAIRMAN: Perhaps just one more. Does  
10 all include what you would now call the uninsurables? I  
11 am not asking for an immediate answer.

12 DR. EMMETT: Could I ask for clarification  
13 sir? There has been so much confusion regarding various  
14 bodies calling, in insurance parlance, an uninsurable.

15 THE CHAIRMAN: I mean the uninsurable from  
16 the medical standpoint.

17 DR. EMMETT: But not from the financial  
18 standpoint?

19 THE CHAIRMAN: No, uninsurable from the  
20 medical standpoint was my question.

21 DR. EMMETT: Yes, it does include the uninsu-  
22 rables from the medical standpoint.

23 THE CHAIRMAN: So that, regardless of what  
24 a person's conditions would be today, that he would be  
25 able to get coverage?

26 DR. EMMETT: That is our plan, yes.

27 THE CHAIRMAN: And I think I have asked you  
28 to amplify at what rate?

29 DR. EMMETT: I am very grateful for your  
30 questions, and I am sure that they will be of assistance



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to amplify at what rate?

DR. EMMETT: I am very grateful for your

question, and I am sure that they will be of assistance



1 to us in order that we might be of assistance to you.

2 THE CHAIRMAN: Yes, thank you very much  
3 Doctor.

4 The Nova Scotia Society for the Care of  
5 Crippled Children.

6  
7 -- EXHIBIT NO. 14: Submission of the Nova Scotia Society  
8 for the Care of Crippled Children.

9  
10 SUBMISSION OF THE NOVA SCOTIA SOCIETY FOR THE  
11 CARE OF CRIPPLED CHILDREN

12 Appearances: Dr. J. Fraser Nicholson, Chairman of  
13 the Medical Advisory Committee  
14 Mr. F.R. MacKinnon  
15 Col. J.M. Kinnaird  
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2 THE SECRETARY: Yes, thank you very much.

3 Doctor.

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9 CARE OF CRIPPLED CHILDREN

10 presented by J. Fraser Nicholson, Chairman of  
11 the Medical Advisory Committee  
12 Mr. J. H. MacLennan  
13 Col. J. M. Kinross

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SUBMISSION OF  
THE NOVA SCOTIA SOCIETY FOR THE CARE OF  
CRIPPLED CHILDREN

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Appearances:

Dr. J. Fraser Nicholson    Chairman of the Medical  
Advisory Committee

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1.        The statements made in this brief are to substantiate our belief that, until the time comes when a system of complete comprehensive medical care will eventually evolve for all Canadian people, Societies such as ours will continue to be essential to the welfare of handicapped and crippled children unable to fend for themselves.

2.        We first began to collect accurate statistics in 1957 on the nature and extent of crippling diseases and handicaps in children. These facts, available to all agencies Government and private, are therefore, as yet very incomplete.

3.        Case finding and follow-up leave much to be desired. The Society is emphasizing early detection and treatment, and believes it has a unique function to perform in this area of responsibility.

4.        We believe that no handicapped or crippled child should lack necessary treatment, therefore, we operate on the broadest possible definition of a crippled child.

5.        We believe our functions to be:

SUBMISSION ON

THE NOVA SCOTIA SOCIETY FOR THE CARE OF

CRIPPLED CHILDREN

Dr. J. Fraser Nicholson  
Chairman of the Medical  
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1 (a) To identify gaps in existing services  
2 available to handicapped children and to establish  
3 the needs for new services.

4 (b) To demonstrate to the public, private  
5 and professional groups, and individuals, how neces-  
6 sary services may best be provided.

7 (c) To promote a programme of education  
8 with all lay and professional persons concerned with  
9 crippled children, so that such children will have  
10 an opportunity for treatment and so that facilities  
11 will be available for such treatment.

12 (d) To press for the provision by the  
13 Government of such services as are properly the  
14 business of Government.

15 (e) To provide those services that are not  
16 otherwise available.

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20 1. The Nova Scotia Society for the Care of  
21 Crippled Children although formed first in 1930 became  
22 defunct for a number of years due to lack of public  
23 interest and support. Since 1951, when it was re-  
24 organized, it has been increasingly concerned with  
25 the care of crippled and handicapped children in  
26 the province of Nova Scotia. The definition that we  
27 have adopted for a crippled child is - "A child,  
28 that is a person under eighteen years of age, who  
29 suffers from a disability severe enough to interfere  
30 with his obtaining an education or later the earning  
of his livelihood".



- (a) To identify gaps in existing services available to handicapped children and to establish the needs for new services.
- (b) To demonstrate to the public, private and professional groups, and individuals, how necessary services may best be provided.
- (c) To promote a programme of education with all lay and professional persons concerned with crippled children, so that such children will have an opportunity for treatment and so that facilities will be available for such treatment.
- (d) To press for the provision by the Government of such services as are properly the business of Government.
- (e) To provide those services that are not otherwise available.

1. The Nova Scotia Society for the Care of Crippled Children although formed first in 1930 became dormant for a number of years due to lack of public interest and support. Since 1951, when it was re-organized, it has been increasingly concerned with the care of crippled and handicapped children in the province of Nova Scotia. The definition that we have adopted for a crippled child is - "A child, that is a person under sixteen years of age, who suffers from a disability severe enough to interfere with his obtaining an education or later his earning



Up until the Society's reorganization in 1951 and indeed for some time thereafter it was extremely difficult to correct the public image of a crippled child being one that is orthopedically crippled only. Even after ten years the public image of a crippled child is still of one with a crutch, and it is obvious that a good deal more public education must be carried on in this particular area.

It was decided by the Executive of the Society in 1951 that case finding was absolutely essential to any successful programme and with this in mind a crippled children's register was set up. At present there are 8,839 names on the register, (see appendices I and II) which obviously represent only a small number of the crippling conditions existing in the province. It was decided in 1956 to offer Mobile Diagnostic Clinics to areas asking for them, making sure that the work of clinics was done in close cooperation with the family physician and local medical men so that the service might be as diversified as possible. The Clinics have grown until we now have twenty-six per year. (See appendix III). We have increased such services as the provision of wheelchairs, braces, hearing aids, prosthetic devices, etc., and have assisted in the arrangement of transportation for children and parents to treatment centres. In certain areas handicapped children are transported to special school classes. Grants are also made at the discretion of the Executive to organizations working in restricted aspects of helping handicapped children,





Up until the Society's reorganization in 1991 and indeed for some time thereafter it was extremely difficult to correct the public image of a crippled child being one that is out-of-control, crippled only. Even after ten years the public image of a crippled child as still of one with a crutch, and it is obvious that a good deal more public education must be carried on in this particular area.

It was decided by the Executive of the Society in 1991 that case finding was absolutely essential to any successful programs and with this in mind a crippled children's register was set up. At present there are 8,639 names on the register, (see appendices I and II) which obviously represent only a small number of the crippling conditions existing in the province. It was decided in 1986 to offer Mobile Diagnostic Clinics to areas asking for them, making sure that the work of clinics was done in close cooperation with the family physician and local medical men so that the services might be as diversified as possible. The Clinics have grown until we now have twenty-six per year. (See appendix III). We have increased and expanded as the provision of ambulatory, prosthetic, hearing aids, prosthetic devices, etc., and have assisted in the arrangement of transportation for all dress and access to treatment centres. In certain areas handicapped children are transported to special school classes. Grants are also made at the discretion of the Executive to organizations working in

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1 e.g., The Nova Scotia Cystic Fibrosis Parents Council  
2 and the Cerebral Palsy Associations of the Province.

3 3. It is our view that the provision of adequate  
4 health services to crippled and handicapped children  
5 is often hampered by the number of organizations in the  
6 field. Many of these Societies do extremely worthy  
7 work in restricted fields of endeavour - the restric-  
8 tions being often imposed by the diagnosis involved.  
9 Inevitably this leads to gaps and our Society feels  
10 that its proper function is to fill in these gaps so  
11 that no handicapped child needing assistance and  
12 service will be refused because of limitation of  
13 definition or function on our part.

14 4. It is our contention that in spite of the  
15 ever-expanding Public Health Services, the increasing  
16 activities of the Departments of Health and Welfare,  
17 the growing numbers of community nurses and school  
18 nurses, the improvement of rural communications and  
19 transportation, both case finding and case follow-up  
20 leave much to be desired, and in some cases the very  
21 nature of a government agency tends to limit its  
22 usefulness in this particular area.

23 5. Appendices numbers (V), (VI), (VII),  
24 describing case load and two case histories now current  
25 in the files of the Society will illustrate the need  
26 for case finding and follow up. We have conviction that  
27 a lay organization making use of a large number of  
28 volunteers can be extremely effective in community  
29 education and case referral.

30 6. It is obvious from our experience that only



6.3., The Nova Scotia Cystic Fibrosis Parents Council

and the General Palay Associations of the Province.

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is often hampered by the number of organizations in the

field. Many of these societies do extremely worthy

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tions being often imposed by the disabilities involved.

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a lay organization making use of a large number of

volunteers can be extremely effective in community

education and case referral.

6. It is obvious from our experience that only





1 a few who have made it their business to study the  
2 problems of the handicapped and try to find some of the  
3 answers, have any idea of their magnitude both in  
4 terms of the numbers of children affected and the  
5 severity of the individual cases of child handicap.

6 It has been amply demonstrated that the more available  
7 a service is to the public and the better its quality  
8 the greater the demand will be for it. One may  
9 reasonably conclude therefore that having regard to  
10 the tremendous number of cases that have not yet been  
11 discovered, the new individuals that will be born or  
12 will develop handicapped conditions, and the results of  
13 the ever-increasing number of automobile accidents,  
14 the case load will continue to increase into the  
15 foreseeable future.

16 7. We are convinced that help for crippled chil-  
17 dren can best be given by voluntary organizations like  
18 our own working in close cooperation with government.  
19 We believe that at this stage it is essential that we  
20 involve as many citizens as possible in every aspect of  
21 helping handicapped children. The Easter Seal Cam-  
22 paign involves a very large number of people and the  
23 stake which these people have in the entire effort  
24 is of the greatest importance. These are the people  
25 who will press for the help of handicapped and  
26 crippled children. The conviction of these many  
27 ordinary supporters of the Society is necessary if  
28 government is to undertake the mass job of providing  
29 health services which is within its means and capacity.

30 8. Summing up, we believe, the Society has the

a few who have made it their business to study the  
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following functions and responsibilities to perform:

- (1) To identify gaps in the existing services available to handicapped children and to establish the needs for new services.
- (2) To demonstrate to the public, and to private and professional groups and individuals how necessary services may best be provided.
- (3) To promote a programme of education with all lay and professional persons concerned with crippled children, so that such children will have an opportunity for treatment and so that facilities will be available for such treatment.
- (4) To press for the provision by the Government of such services as are properly the business of Government.
- (5) To provide those services that are not otherwise available.





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(5) To provide those services that are not otherwise available.



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Nova Scotia Society for the Care of Crippled Children

APPENDIX (1)  
CENTRAL REGISTRY REPORT - NO. OF CHILDREN BY COUNTIES

COUNTY	Sept. 30 1957	Sept. 30 1958	Sept. 30 1959	Feb. 29 1960	Feb. 28 1961	Sept. 30 1961 7 mos.	To Be Processed	TOTAL REGIS- TRATIONS Oct. 2, 1961
Annapolis	54	69	107	110	142	187	3	190
Antigonish	25	29	43	45	70	79	7	96
Cape Breton	see below	248	531	564	1044	1121	34	1155
Colchester	92	116	236	265	433	452	6	458
Cumberland	62	186	364	388	454	470	8	478
Digby	82	93	141	164	218	271	7	278
Guysboro	126	35	56	110	210	233	---	233
Halifax	465	998	1925	1943	2732	2911	54	2965
Hants	45	95	142	151	320	339	65	404
Inverness	79	125	161	165	243	260	1	261
Kings	67	134	196	204	285	308	132	440
Lunenburg	104	143	259	272	389	403	1	404
Pictou	63	156	268	278	379	392	2	394
Queens	32	54	118	119	152	169	3	172
Richmond	see below	81	99	100	147	156	---	156
Shelburne	83	111	165	168	195	213	10	223
Victoria	27	36	72	78	101	102	---	102
Yarmouth	87	111	170	170	233	296	118	414
No location	---	---	---	---	---	26	---	26
Richmond & CB	123	---	---	---	---	---	---	---
TOTAL	1526	2820	5053	5294	7747	8388	451	8839*
Increase from Previous report	1526	1294	2233	241	2453	1092		

\* Statistics are accumulating at the rate of 75 per month.

This figure is therefore quite incomplete as a count of the  
total number of crippled and handicapped children in the  
Province.



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Nova Scotia Society for the Care of Crippled Children

APPENDIX (1)

CENTRAL REGISTRY REPORT - 101 ON CHILDREN BY COUNTY

COUNTY	Sept. 30 1937	Sept. 30 1938	Sept. 30 1939	Sept. 30 1940	Sept. 30 1941	Sept. 30 1942	To Be Processed	INITIAL REGIS-TRATIONS
Antigonish	25	29	43	45	70	107	7	89
Cape Breton	248	281	294	1094	1121	34	1129	
Colchester	92	116	236	262	433	432	6	428
Cumberland	62	186	261	308	451	470	8	470
Dorchester	82	92	141	161	218	271	7	278
Guysboro	26	32	26	110	210	233	---	233
Halifax	402	908	1922	1942	2732	2911	24	2962
Hants	42	62	142	121	226	299	62	401
Inverness	79	122	161	162	243	260	1	261
Kings	61	121	196	204	282	308	132	460
Lebanon	104	142	226	212	386	402	1	401
Pictou	62	126	266	278	379	392	2	391
Queens	32	24	118	119	122	160	3	172
Richmond	61	61	92	100	141	186	---	126
Shelburne	82	111	162	162	192	210	10	229
Victoria	21	36	72	78	101	102	---	102
Yarmouth	67	111	170	176	222	292	118	414
No location	---	---	---	---	---	---	---	26
Richmond & CB	123	---	---	---	---	---	---	---
TOTAL	1286	2820	3023	2944	7142	8486	421	8709

Increase from

\* Statistics are accumulating at the rate of 72 per month.

This figure is therefore quite incomplete as a count of the

total number of crippled and handicapped children in the

Province.





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Nova Scotia Society for the Care of Crippled Children

APPENDIX (II)

CENTRAL REGISTRY REPORT - NUMBER BY DISABILITIES

Page 1

DISABILITY	Sept. 30 1957	Sept. 30 1958	Sept. 30 1959	*Feb. 29 1960	Feb. 28 1961	Sept. 30 1961 7 mos.	TO BE PROCESSED	TOTAL DISABILITIES Oct. 2, 1961
Birth Injuries	---	---	---	6	8	10		10
Bones & Joints	54	161	245	326	426	468	13	481
Brain Anomalies	81	167	275	137	195	210	14	224
Burns	4	9	10	14	17	17		17
Cancer	1	1	2	5	3	7		7
Cerebral Palsy	105	243	335	349	435	465	2	467
Cleft Palate	15	74	112	245	278	292	11	303
Club Feet	68	117	166	182	218	237	16	253
Collagen Disease	---	---	---	4	3	3		3
Diabetes	19	42	85	85	104	110	1	111
Diseases of the Blood	---	1	21	38	53	62	3	65
Diseases of the Kidneys	9	28	73	90	120	148	4	152
Diseases of the Muscles	18	48	73	112	143	150	1	151
Cystic Fibrosis	---	4	45	56	72	83	3	86
Epilepsy	---	---	---	239	300	349	12	361
Eye Disease	156	317	536	722	1015	1188	21	1209
Gastro-Intestinal	8	12	14	27	36	44	1	45
Genito-Urinary	---	---	---	7	28	34	3	37
Gland Disfunction	1	7	11	34	49	57	3	60
Hare lip	3	34	63	100	120	136	8	144
Hearing	54	196	279	281	445	592	145	737
Heart	46	126	228	297	393	458	10	468
Liver	---	1	1	---	1	1	1	2
Lung	---	---	---	---	6	7		7
Mental Illness	---	2	4	30	36	37		37



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None. Secord Society for the Care of Crippled Children

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Nova Scotia Society for the Care of Crippled Children

APPENDIX (II)

CENTRAL REGISTRY REPORT - NUMBER BY DISABILITIES

Page 2

Mental Retardation	144	297	1092	1307	1712	1861	79	1940
Neoplasms	---	---	---	---	2	2		2
Neurosis	---	---	---	---	---	1		1
Other	101	155	245	107	43	47		47
Polio	363	381	396	358	387	390		390
Rheumatoid Arthritis	4	9	10	10	11	14	1	15
Rheumatic Fever	25	45	70	87	112	126	2	128
Skin	---	4	5	13	17	19		19
Severe Allergy	15	65	106	135	160	167		167
Speech	256	488	976	1138	1833	1894	2	1896
T. B.	20	41	43	35	93	108	2	110
T. B. Bones	---	---	---	24	33	33		33
Trauma	2	4	4	4	4	4		4
Tumor	---	4	6	15	19	21		21
No Diagnosis	---	---	---	51	86	94		94

\* The method of classification was changed prior to this report.





Have Georgia Hospitals for the year of 1914 been

CENTRAL REGISTRY REPORT - NUMBER BY INSTITUTION

Mental	140	200	1000	1000	1000	1000	1000	1000	1000
Residential	140	200	1000	1000	1000	1000	1000	1000	1000
Neoplasms	140	200	1000	1000	1000	1000	1000	1000	1000
Leucemia	140	200	1000	1000	1000	1000	1000	1000	1000
Genet	140	200	1000	1000	1000	1000	1000	1000	1000
Pelvic	140	200	1000	1000	1000	1000	1000	1000	1000
Atrophic	140	200	1000	1000	1000	1000	1000	1000	1000
Rheumatic	140	200	1000	1000	1000	1000	1000	1000	1000
Fever	140	200	1000	1000	1000	1000	1000	1000	1000
Skin	140	200	1000	1000	1000	1000	1000	1000	1000
Severe	140	200	1000	1000	1000	1000	1000	1000	1000
Alcohol	140	200	1000	1000	1000	1000	1000	1000	1000
Speech	140	200	1000	1000	1000	1000	1000	1000	1000
T. B.	140	200	1000	1000	1000	1000	1000	1000	1000
T. B. Bones	140	200	1000	1000	1000	1000	1000	1000	1000
Tumor	140	200	1000	1000	1000	1000	1000	1000	1000
No Diagnosis	140	200	1000	1000	1000	1000	1000	1000	1000

\* The method of classification was changed prior to this report.



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APPENDIX (III)

NOVA SCOTIA SOCIETY FOR THE CARE OF CRIPPLED CHILDREN  
MOBILE CLINIC PROGRAMME

YEAR	NUMBER OF CLINICS	NUMBER OF PATIENTS ATTENDING	NUMBER OF NEW PATIENTS ATTENDING	*NUMBER OF CONSULTATIONS				COST OF OPERATING MOBILE CLINICS
				Paediatric	Orthopaedic	Psychological	Eye, Ear, Nose & Throat	
1957	16	757						\$2,862.67
1958	21	669						\$3,959.92
1959	23	658						\$3,932.77
1960	24	787	352	387	400			\$4,189.91
1961 (May only)	13	518	280	198	292	6	54	\$2,234.86 (6 month period)

\*Statistics on consultations previous to 1960 not available.



NATIONAL SOCIETY FOR THE CARE OF ORPHANED CHILDREN

ATTENDING				Per. H.		Per. H.		Per. H.		Per. H.	
ATTENDING				Per. H.		Per. H.		Per. H.		Per. H.	
1937	16	727	16,886.84	24	8	198	105	24	8	198	105
1938	21	693	36,060.84								
1939	23	666	37,580.84								
1940	24	781	44,160.84			391	100				
1941	19	913	45,524.86			198	105				

\*Statistics on consultations as of 1940 not available.





APPENDIX IV

SPEECH THERAPY PROGRAMME

<u>Year</u>	<u>Clinics Held</u>	<u>Patients Treated</u>	<u>Cost</u>
1957	9	251	\$2,928.22
1958	9	388	\$3,961.17
1959	8	502	\$3,642.00
1960	10	719	\$6,551.76



1900

THE UNIVERSITY OF CHICAGO

LIBRARY

THE UNIVERSITY OF CHICAGO

DATE	RECEIVED	BY	REMARKS
1900	10	10	10
1900	10	10	10
1900	10	10	10
1900	10	10	10



APPENDIX (V)

CASE LOAD OF THE NOVA SCOTIA SOCIETY FOR THE  
CARE OF CRIPPLED CHILDREN

February 28, 1961 (End of Society's fiscal year)      September 15, 1961

Case Load      1702      2061

Discharged:      251      261

Improved:      Unnecessary to return to clinic

Over age:      Referred to other agencies

Moved out of province:      Referring to other agencies

Deceased

Previous figures not available.

TOTAL REGISTERED:      1953      2372



# CASE LOAD ON THE NOVA SCOTIA SOCIETY FOR THE

## CARE OF ORPHAN CHILDREN

Case Load 1902 1903

Discharged: 213

Improved: Unnecessary return to state

Over age: Referred to other agencies

Moved out of province: Referring to other agencies

Previous cases not available

TOTAL ADOPTIONS: 1902 1903



APPENDIX (VI)

CASE HISTORY 1

1. Judy has been deaf and has been partly paralyzed on her left side since infancy. Her parents apparently believed that nothing could be done to help her and had made no attempt to secure medical treatment for her. She attended the rural school but made very little progress because of her disabilities, although her teacher thought that she had potential ability which might be worth developing.

2. In 1957 when the Society began Mobile Clinics in her area, through the encouragement of the Public Health Nurse and the advice of the family doctor Judy was assessed at the Mobile Clinic. Recommendations for further assessment and treatment were made but the Society did not have a fully developed follow-up service at the time and nothing further was done. Judy was then 13.

3. When follow-up services were instituted in 1960, it was found that Judy, now 17 years of age, was a ward of the local Children's Aid Society. There seemed to be little hope for her except a life of dependency as a recipient of Social Assistance.

4. With the cooperation of the foster mother, the Children's Aid Society and her family doctor she was again seen at the Mobile Clinic. At that time the clinician reported as follows:

"Briefly, my feeling is that this girl can and should be educated. I believe that she has some hearing which should be utilized if supplemented by a



1. Judy has been deaf and her hearing is very poor. She was born deaf and her hearing is very poor. Her parents were advised on her deafness since infancy. Her parents apparently believed that nothing could be done to help her and had made no attempt to secure medical treatment for her. She attended the rural school but made very little progress because of her deafness. Although her teacher thought that she had potential ability which might be worth developing.

2. In 1937 when the Society began Mobile Clinics in her area, through the encouragement of the Public Health Nurse and the advice of the family doctor Judy was assessed at the Mobile Clinic. Recommendations for further assessment and treatment were made but the Society did not have a fully developed follow-up service at the time and nothing further was done.

Judy was then 12. When follow-up services were instituted in 1938, it was found that Judy, now 13 years of age, was a ward of the Local Children's Aid Society. When assessed to be little hope for her except a life of dependency as a recipient of Social Assistance.

3. With the cooperation of the Society Nurse, the Children's Aid Society and the family doctor, Judy was taken to the Mobile Clinic. At that time the children reported as follows:  
"Initially, my 'feeling' is that this girl is and a whole lot more. I believe that she has some





1 hearing device to give her, perhaps a complete  
2 education, preferable under the auspices of qualified  
3 teachers, such as personnel of the School for the Deaf.  
4 The important thing that I would like to stress is that  
5 I do not believe that this girl is retarded and I  
6 think that if allowances could be made for her  
7 previous poor environment and complete lack of edu-  
8 cation a psychologist would rate her as average intelli-  
9 gence. The degree of physical deformity caused by  
10 the left hemiplegia is minimal and should interfere  
11 very little with her education and rehabilitation  
12 programme.

13 "She has become lost in the maze of brief,  
14 hurried welfare and medical interviews over the past  
15 few years and as a result, many important years of  
16 her rehabilitation have been lost. I am not suggesting  
17 that this is anybody's fault, but rather, it is a  
18 reflection of the lack of facilities and workers in  
19 our field."

20 5. The Society through its Franchise Holder  
21 provided a hearing aid for Judy and arranged to have her  
22 admitted to the School for the Deaf, although she was  
23 somewhat over their usual age limit.

24 6. With this assistance we hope that Judy may  
25 become an independent, productive individual rather  
26 than a burden to herself and society.

27 7. We hope that the expanded facilities of the  
28 Society will prevent, in the future, the time lapse which  
29 occurred in this case and which is still apparent in many  
30 other cases coming to the Society for help.





APPENDIX (VII)

CASE HISTORY 2

1. James was born in 1944, appeared at the age of 16 as a patient for the first Mobile Clinic held in the district. He was accompanied by his mother, most resentful against the boy, whom, she considered was deliberately at fault.

2. The boy was despondent. His history, taken by the clinician was of bowel evacuation incontinence. He was not trained from childhood. Ridiculed at school and soundly thrashed at home, he had ceased to attend school at Grade 5; and his life was one of hanging around home keeping out of everybody's way.

3. The family doctor had not been consulted. However, the District Public Health Nurse arranged with the local physician and the boy's mother to have James referred to the Mobile Diagnostic Clinic which was to be held the following month in the district.

4. James, too old for the Halifax Children's Hospital, was examined and recommended for a thorough examination at the Victoria General Hospital, Halifax.

5. The hospitalization was carried out and the boy reappeared at the November clinic for a check-up.

6. Surgery and drugs has now improved his condition to the extent that he may be classed as normal. He is bright, cheerful; but rather than return to school, which would mean Grade 6 at 17 years of age, he has gone to work.

7. Here again, it is hoped that early case finding and diagnosis will help to avoid the unnecessary suffering, frustration and lack of understanding so evident in the foregoing.



## CASE HISTORY

1. James was born in 1944, appearing at the age of 10 as a patient for the first time in the district. He was accompanied by his mother, most resistant against the boy, whom she considered was deliberately at fault.

2. The boy was dependent. His history, taken by the clinician was of bowel evacuation infrequently. He was not trained from childhood. He was not toilet trained at school and only thrashed at home. He had ceased to attend school at Grade 5; and his life was one of having around some keeping out of everybody's way. The family doctor had not been consulted.

3. However, the District Public Health nurse arranged with the local physician and the boy's mother to have James referred to the Mobile Diagnostic Clinic which was to be held the following month in the district.

4. James, now aged 10, the Mobile Diagnostic Clinic, was examined and recommended for a thorough examination at the Victoria General Hospital, Halifax. The hospitalization was carried out and the boy responded at the November clinic for a check-up.

5. Surgery and drugs has now improved his condition to the extent that he may be cleaned at home. He is bright, cheerful; but rather than a child who would read Grade 6 at 14 years of age, he has

and to read.

6. From a point, it is hoped that early case finding

and diagnosis will help to avoid the wasted cost of a



1 COMMISSIONER FIRESTONE: Dr. Nicholson, I  
2 am asking my standard question, and that is, do you feel  
3 that sufficient funds have been, or are, available to develop  
4 a comprehensive and realistic program for the care of crippled  
5 children in the Province of Nova Scotia, and if such  
6 adequate funds are not available, what would be a desirable  
7 budget? Would this information be made available to the  
8 Commission?

9 DR. NICHOLSON: In the present stage of our  
10 knowledge, sir, I doubt very much if that is possible.  
11 Our case-finding is far from complete, it is just complete  
12 enough to make us realize that the problem is very considerable  
13 as is quite amply pointed out in the appendices.  
14 At present our Society has ample funds to do what it is  
15 currently doing, and is receiving a good deal of help  
16 from both private and public funds. I really couldn't  
17 draw up a budget.

18 COMMISSIONER FIRESTONE: Could you perhaps  
19 suggest to us what some of the things are that could be  
20 done in this field that are not being done at this stage?  
21 Would you be in a position to do so as a result of the  
22 experience which you have gained so far, or which you may  
23 be gaining in the next few months?

24 DR. NICHOLSON: The experience of our case-  
25 finding mechanisms and of our clinics is that very large  
26 numbers of children exist with minor and even major  
27 degrees of mental defect, for whom ample facilities for  
28 training and care do not exist. Within my own knowledge  
29 we have occasional demands for facilities to treat very  
30 disturbed children which do not exist, psychiatrically



COMMISSIONER WILKINSON: Dr. Nicholson, I

am asking you a leading question, and that is, do you feel

that a national fund, have been, or are, available to develop

a comprehensive and realistic program for the care of retarded

children in the Province of Nova Scotia, and if such

adequate funds are not available, what would be a realistic

budget? Would this information be made available to the

Commission?

DR. NICHOLSON: In the present stage of our

knowledge, sir, I don't very much think it is possible.

Our case finding is far from complete. It is just complete

enough to make us realize that the problem is very complex

table as a quite simply pointed out in the appendix.

At present our Society has ample funds to do what it is

currently doing, and is receiving a good deal of help

from both private and public funds. I really couldn't

draw up a budget.

COMMISSIONER WILKINSON: Would you perhaps

suggest to us what some of the things are that could be

done in this field that are not being done at this stage?

Would you be in a position to do so as a result of the

experience which you have gained so far, or which you may

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degrees of mental defect, for whom ample facilities for

training and care do not exist. Within my own knowledge,

we have occasional demands for facilities to treat very

of retarded children which do not exist, particularly in





1 disturbed children. While agencies exist for the blind  
2 and the deaf and other handicapped conditions like these,  
3 still a good deal is still necessary to be done at the  
4 level of the home and the home community, rather than a  
5 central organization like the Nova Scotia Institute for  
6 the Blind and so forth and so on.

7 COMMISSIONER FIRESTONE: I take it you have  
8 some plans for doing more to improve the care of crippled  
9 children. Are you planning to do more than you have done  
10 so far?

11 DR. NICHOLSON: Yes sir.

12 COMMISSIONER FIRESTONE: Can you let us  
13 know what are some of those desirable things that could and  
14 should be done? If we don't get information from people  
15 like yourself, to know something of the problem, where are  
16 the Commission to get their information?

17 DR. NICHOLSON: This is one of the chief  
18 purposes of our brief, to give the Commission the informa-  
19 tion we have gathered, and that is included in our appen-  
20 dices.

21 COMMISSIONER FIRESTONE: This is very helpful  
22 as far as factual information, but can we also have your  
23 judgment as to what should be done about it?

24 DR. NICHOLSON: Yes sir.

25 COMMISSIONER FIRESTONE: So we can expect  
26 a further statement on this point?

27 DR. NICHOLSON: Our national organization is  
28 making a much more comprehensive brief on this subject,  
29 and certainly this is considered to be a preliminary state-  
30 ment of our own experience.





1 COMMISSIONER FIRESTONE: Would the national  
2 organization submit us a brief outlining the problems of  
3 Nova Scotia, or would it not be better to get the require-  
4 ments of Nova Scotia from you?

5 DR. NICHOLSON: Yes sir, you are right sir.

6 COMMISSIONER FIRESTONE: So we can expect  
7 something from you regarding the requirements of the  
8 Province of Nova Scotia?

9 DR. NICHOLSON: Yes sir.

10 THE CHAIRMAN: I take it that in the  
11 national brief, because you are a voluntary organization,  
12 that this question again of the place of the voluntary  
13 organization in relation to crippled children in this  
14 instance, will be given consideration and perhaps we may  
15 be given your ideas in any event that will help, as to how  
16 such a voluntary organization will fit in, or might fit into  
17 a pattern of a comprehensive medical services program?

18 DR. NICHOLSON: Is this a question sir?

19 THE CHAIRMAN: Yes, it is a question, it is  
20 a request actually.

21 DR. NICHOLSON: I doubt if the question  
22 would be answered in just that way in the brief of the  
23 national organization.

24 THE CHAIRMAN: Well, would you mind bringing  
25 it to the attention of your national organization that  
26 the Commission is interested in being given some help and  
27 viewpoints along the lines I have indicated?

28 DR. NICHOLSON: Yes my lord.

29 COMMISSIONER BALTZAN: Mr. Chairman, I have  
30 a general problem which is not directed to the gentleman







1 before us. Perhaps we should take it up at another time,  
2 but I will leave this out as a floater, because I am not  
3 certain where we stand with respect to this, and even  
4 after listening to a lot of briefs. The thing I would  
5 like to have explained to me, and perhaps the rest of the  
6 Commission: "Requests for the provision by the Government  
7 for such services as are properly the business of Govern-  
8 ment". Maybe we could get assistance from elsewhere. Is  
9 there a definition as to what is properly the business of  
10 the Government? I don't want any answer now, but I hope  
11 to get it before we are through.

12 THE CHAIRMAN: Dr. Nicholson, I take it that  
13 your funds come from voluntary contribution?

14 DR. NICHOLSON: Almost completely my lord.  
15 We do have considerable help from the Provincial Government  
16 as well in the financing of our clinics.

17 THE CHAIRMAN: And I take it that that infor-  
18 mation would come in as part of the financial picture that  
19 Dr. Firestone spoke about?

20 DR. NICHOLSON: Yes my lord.

21 THE CHAIRMAN: Thank you very much Dr.  
22 Nicholson and gentlemen.

23 There is one matter yet to be dealt with  
24 this afternoon. You have a letter from Mr. Burton?

25 MR. HALL: At the preliminary meeting in  
26 Ottawa Mr. John S. Burton appeared on behalf of the  
27 Canadian Chiropractic Association and he has directed a  
28 letter to the Secretary in connection with an erroneous  
29 quotation he made from a brief presented by the Medical  
30 Association.



1 before me. Perhaps we should take it up at another time.  
2 but I will leave this out as a flier, because I am not  
3 certain where we stand with respect to this, and even  
4 after listening to a lot of people. The thing I would  
5 like to have explained to me, and perhaps the rest of the  
6 Committee. I suppose the position for the Government  
7 in the services as the property, the business of Govern-  
8 ment, and the way you see it from elsewhere. Is  
9 there a difference as to what the property the business of  
10 the Government? I don't want any answer now, but I hope  
11 to get it before we are through.

12 The Chairman: Mr. Nicholson, I take it that

13 the Government help from the Provincial Government  
14 in the financing of our affairs.

15 The Chairman: And I take it that that infor-

16 The Chairman: Thank you very much Sir.

17 The Chairman: Thank you very much Sir.

18 The Chairman: Thank you very much Sir.

19 The Chairman: Thank you very much Sir.

20 The Chairman: Thank you very much Sir.

21 The Chairman: Thank you very much Sir.





1 In view of the fact that it is a matter of  
2 a correction of the quotation of another organization  
3 appearing, I would suggest that the letter be filed as  
4 part of the record.

5 THE CHAIRMAN: Very well.

6 October 24th, 1951

7 Re: Canadian Chiropractic Association

8 Dear Sir,

9 On September 28th, 1961, on behalf of the  
10 Canadian Chiropractic Association, I made a preliminary  
11 statement to the Commission. Erroneously, I read what I  
12 thought to be a quotation from a brief presented the  
13 previous day, by the Medical Association.

14 My error appears in the official transcript  
15 of the proceedings, page 192, commencing at line 16,  
16 reading as follows:

17 "Yesterday, the Canadian Medical Association's  
18 brief had this to say and I quote it as nearly accurately  
19 as I can, 'Our desire' said the brief, 'is to see that the  
20 people of Canada should receive the best and most compre-  
21 hensive care. It is not essential nor desirable that any  
22 one segment of the population of the serving organizations  
23 which make up the entire field of socio-medical services  
24 should cause to be eliminated from that comprehensive care  
25 any other service or any form of care under any circum-  
26 stances so that any individual portion of the population  
27 should be denied the services which could be made available  
28 to them'. In my humble submission, that is a very essen-  
29 tial and worthwhile contribution which the Canadian Medical  
30 Association made because ---" (ending in the middle of



In view of the fact that it is a matter of

2 a comparison of the production of another organization

Very well.

October 24th, 1951

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0 Can draw anthropometric Association, I made a preliminary

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thought to be a quotation from a brief presented the

14 My error appears in the official transcript

of the transcript, page 102, commencing at line 10,

16 that section said the brief, "to be seen that the

21 sentence said, "It is not essential nor desirable that any

22 one segment of the population of the serving organizations

23 which may be the field of social medical services

24 should come to be identified from that comprehensive care

25 any other factor or any form of the order any other

26 factor as to that any individual portion of the population

27 should be denied the services which could be made available

28 to my family association, that is a very serious

29 that and the association with the United Medical

30 Association of the United States in the field of



1 line 29).

2                   Confirming my previous correspondence with  
3 you, I should like the transcript corrected, to delete  
4 reference to the quotation as emanating from the brief of  
5 the Canadian Medical Association and in its place, to  
6 insert the following:

7                   "It is the desire of the Canadian Chiroprac-  
8 tic Association to see that the people of Canada receive  
9 the best and most comprehensive care. It is not essential  
10 nor desirable that any one segment of the population of  
11 the serving organizations which make up the entire field  
12 of socio-medical services should cause to be eliminated  
13 from that comprehensive care any other service or any form  
14 of care under any circumstances so that any individual  
15 portion of the population should be denied the services  
16 which could be made available to them".

17                   The transcript will then continue after the  
18 word "because" in line 29.

19                   I very much appreciate your assistance to me  
20 in respect of this correction and regret the incident.

21                   Yours sincerely,  
22 JSB/ekp                   (sgd) JOHN S. BURTON

23                   THE CHAIRMAN: That brings us up to date  
24 at this point so far as the hearing of the Associations  
25 who were warned that they might be heard today. We will  
26 proceed tomorrow morning with the submission from the  
27 Nova Scotia Association for Retarded Children, and will  
28 reconvene at 9.30 tomorrow morning.

29 --- Whereupon the hearing adjourned until 9.30 a.m.,  
30 Wednesday, November 1st, 1961.





# ROYAL COMMISSION ON HEALTH SERVICES

## HEARINGS

HELD AT

**HALIFAX**

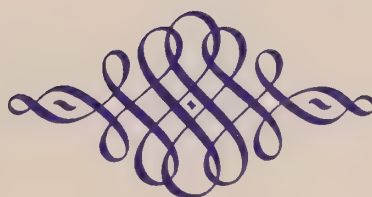
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SUBMISSION

to the

ROYAL COMMISSION ON HEALTH SERVICES

by the

NOVA SCOTIA PHARMACEUTICAL SOCIETY

For presentation in Halifax, Nova Scotia

October 30, 31 & Nov. 1, 1961



For presentation in Halifax, Nova Scotia  
October 30, 31 & Nov. 1, 1961

NOVA SCOTIA PHARMACEUTICAL SOCIETY  
by the  
ROYAL COMMISSION ON HEALTH SERVICES  
to the  
Commission



SUBMISSION

to the

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by the

NOVA SCOTIA PHARMACEUTICAL SOCIETY

INTRODUCTION:

1. This submission is respectfully made to the Royal Commission on Health Services by the Nova Scotia Pharmaceutical Society. This Society was founded in 1875 and incorporated by Chapter 11, of the Acts of the Legislature of Nova Scotia, passed in the year 1876. The preamble to that Act read as follows:

"Whereas it is expedient for the safety of the public, that all persons engaged in the sale or dispensing of drugs and medicines within this Province should be acquainted with their properties and uses, and possess a competent practical knowledge of pharmacy; and that provision be made for testing the knowledge and capability of all persons hereunder proposing to engage in the aforesaid business:

"Be it therefore enacted by the Governor, Council and Assembly as follows:"

The Society created by that Act has continued and is presently governed by Chapter 216, Revised Statutes of Nova Scotia, 1954 as amended by Chapter 37 of the Acts of 1957. The Society has had the revision of this legislation under intensive review for the past three years, and a new draft Act has been prepared in preliminary





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INTRODUCTION

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 of all persons hereunder proposing to engage in  
 the apothecary business:

"Be it therefore enacted by the Governor,

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The Society created by that Act has continued and is  
 presently governed by Chapter 216, Revised Statutes of  
 Nova Scotia, 1929 as amended by Chapter 17 of the Acts  
 of 1937. The Society has had the revision of that legisla-  
 tion under intensive review for the past three years,  
 and a new draft Act has been prepared in preliminary



1 form. This was given tentative approval by the Society  
2 at its 1961 annual meeting.

3 2. A summary of the provisions of the Pharmacy  
4 Act is attached to this submission as Appendix "A" and  
5 an office consolidation of the Act is submitted as Ex-  
6 hibit "A". The regulations are Exhibit "B".

7 3. Certain terms are defined in Appendix "B".  
8 These definitions are necessary for clarity as the  
9 Pharmacy Act creates three classes of "pharmacists" in  
10 Nova Scotia, a situation which we believe to be unique  
11 in Canada. If a new Act is submitted to the Legislature  
12 for approval, it will probably abandon this division of  
13 the profession and return to one classification of regis-  
14 tered pharmacist.

15 4. The membership of the Society consists of:

- 16 (a) 223 registered pharmaceutical pharmacists;  
17 and  
18 (b) 4 registered hospital pharmacists.

19 There are no registered wholesale pharmacists. These  
20 figures are as of the 1st day of June, 1961. The Society  
21 also has 3 honorary members, but these members cannot  
22 practice pharmacy on the strength of this membership.  
23 There are also approximately 20 associate members who  
24 are not actively engaged in the practice of pharmacy.  
25 In addition "observer privileges" are extended from time  
26 to time to visiting pharmacists, but this does not carry  
27 with it the privilege of practicing pharmacy in Nova  
28 Scotia. Students enrolled with the College of Pharmacy  
29 at Dalhousie University number 78. Certified clerks  
30 are registered under the Act, but are not members of  
the Society. Exhibit "C" is a list of registered mem-  
bers and certified clerks.

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A summary of the provisions of the Pharmacy  
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and registered under the Act, but are not members of  
the Society. Exhibit "E" is a list of registered mem-





5. There are no drug manufacturing establishments in Nova Scotia. Three firms carry on business as wholesalers of drugs, and they operate four wholesale drug outlets. There are 176 retail drug outlets and 51 hospital drug outlets in Nova Scotia.

6. The Society is affiliated with other provincial pharmaceutical associations in the Canadian Pharmaceutical Association, Inc. There are several specialized associations within Nova Scotia.

(a) The Halifax Retail Druggists Association, which is an unincorporated association of pharmacists operating retail drug outlets in the Halifax area. The great majority of members in the Halifax area support the Association.

(b) The Hospital Pharmacists Association, which is an unincorporated association of pharmacists engaged in hospital drug outlets in Nova Scotia. This is a division of the Canadian Society of Hospital Pharmacists, and has approximately 20 members.

(c) The Society is unofficially organized into a number of Zones on a geographical basis in the Province. These Zones hold meetings and deal with purely local problems effecting the practice of pharmacy in their particular areas.

7. Members of the Society participate actively in the following national organizations serving pharmacy and the Canadian public:

There are no other manufacturing establishments in Nova Scotia. Three firms carry on business as wholesale sellers of drugs, and they operate four wholesale drug outlets. There are 176 retail drug outlets and 51 hospital drug outlets in Nova Scotia.

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(c) The Society is unofficially organized into a number of zones on a geographical basis in the Province. These zones hold meetings and deal with purely local problems affecting the practice of pharmacy in their

Members of the Society participate actively in the following national organizations serving pharmacy and the Canadian public:



- (a) Canadian Pharmaceutical Association,
- (b) Canadian Society of Hospital Pharmacists,
- (c) Canadian Foundation for the Advancement of Pharmacy, and
- (d) Canadian Conference of Pharmaceutical Faculties.

8. A brief summary of the establishment aims and history of the Maritime College of Pharmacy is attached as Appendix "C".

9. The Society participates in the Atlantic Provinces Pharmaceutical Advisory Council (APPAC). As its name indicates, the Council is an advisory body composed of the President, Registrar and one other member from each of the Pharmaceutical Societies and Associations of the Maritime Provinces. The Dean of the Maritime College of Pharmacy is also a member of Council. The Council provides a clearing house where topics of common interest to pharmacists of the Maritime area may be aired and recommendations of an advisory nature made to the respective provincial bodies in matters for the betterment of pharmacy and the service rendered by pharmacists to the public. Working through APPAC the three Maritime Pharmaceutical Societies arrived at a reciprocal arrangement permitting the transfer of registered pharmacists from province to provinces. This is the first step of which we are aware in Canada towards freedom of professional movement between provinces. The goal is a common examining board for Canada with licensing remaining an item of provincial jurisdiction.

10. A list of the Officers, Council Members and Officials of the Society is attached as Appendix "D".

11. The aims of this submission are:



- (a) Canadian Pharmaceutical Association,
- (b) Canadian Society of Hospital Pharmacists,

(c) Canadian Conference of Pharmaceutical Societies

A brief summary of the establishment and history of the Maritime College of Pharmacy is attached as Appendix "C".

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vince Council, the Council is an advisory body composed of the President, Registrar and one other member from

each of the Pharmaceutical Societies and Associations

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1 (a) To present certain information, opinions  
2 recommendations pertaining to pharmacy in Nova Scotia.

3 (b) To state the intention of the Society to  
4 assist the Commission in its studies if requested to do  
5 so. The Society assures the Commission of its co-  
6 operation.

7 (c) To reserve the Society's right to make  
8 further submissions to the Commission if the Society  
9 deems it advisable to do so.

10 (d) To present the view of the Society as  
11 to the areas and problems pertaining to pharmacy in  
12 Nova Scotia which should be covered by the Commission  
13 in its investigations and/or deliberations.

14 12. The areas and problems suggested are those  
15 which the Society believes will yield the most signifi-  
16 cant information to the Commission. It is realized that  
17 other organizations and individuals may suggest addition-  
18 al pharmacy problems of interest and importance. It is  
19 hoped that such will be the case. Reference is here  
20 made to Appendix "E" which elaborates on the suggested  
21 areas of study. Time and limited facilities make it  
22 impossible for the Society to conduct these studies.  
23 It is hoped that they will commend themselves to the  
24 Commission.

25 13. A study of the existing facilities and methods  
26 of providing personal health services including preven-  
27 tion, diagnosis, treatment and rehabilitation involves  
28 two things as far as pharmacy is concerned. First, the  
29 scope of professional responsibility of pharmacy, and  
30 second, the present methods of providing drugs and  
pharmaceutical services in Nova Scotia.



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second, the present methods of providing drugs and





1 14. The Society believes the first will be dealt  
2 with exhaustively by the Canadian Pharmaceutical Associa-  
3 tion, and the Society reserves comment at the present  
4 time. It will undoubtedly associate itself with the  
5 Association's presentation, and may, with the Commission's  
6 permission, make further submissions at a later date.

7 15. (a) On the second matter that Society presents the  
8 following. The making of pharmaceutical services uni-  
9 versally available to Canadians entails:

10 retail (a) all research into the production of  
11 Exhibit "A", drugs, chemicals and compounds used for  
12 the prevention, diagnosis, treatment or  
13 rehabilitation of a pathological condition;

14 (b) making available results of all studies  
15 and reports pertaining to the use of the above drugs,  
16 other drugs, chemicals or compounds to the medical pro-  
17 fessions, as well as supplying to the pub-  
18 lic and particularly to other members of

19 16. In the health team necessary information for  
20 safe and effective administration of these prepara-  
21 tions;

22 services (c) supplying medication to the public on the  
23 verbal, handwritten order of a duly qualified medical  
24 practitioner, dentist or veterinarian.

25 (d) that training of pharmacists to insure  
26 adequate pharmaceutical services for the  
27 people of Nova Scotia; and

28 (e) the establishment and maintenance of

29 17. drug outlets in conformity with existing  
30 the Department Federal and Provincial legislation.



The Society believes the first will be dealt with exclusively by the Canadian Pharmaceutical Association, and the Society reserves comment at the present time, and it will undoubtedly associate itself with the Association's presentation, and may, with the Commissioner, make further submissions at a later date. On the second matter that Society presents the following. The making of pharmaceutical services universally available to Canadians entails:

- (a) all research into the production of drugs, chemicals and compounds used for the prevention, diagnosis, treatment or rehabilitation of a pathological condition
- (b) making available results of all studies pertaining to the use of the above drugs, chemicals or compounds to the medical professions, as well as applying to the public and particularly to other members of the health team necessary information for the safe administration of these preparations
- (c) supplying medication to the public on the written order of a duly qualified medical practitioner, dentist or veterinarian
- (d) exact training of pharmacists to insure adequate pharmaceutical services for the people of Nova Scotia; and
- (e) the establishment and maintenance of drug outlets in conformity with existing



1 16. Pharmaceutical services and drugs are pro-  
2 vided to the people of Nova Scotia from the following  
3 sources:

- 4 (a) retail drug outlets;
- 5 (b) hospital drug outlets;
- 6 (c) Department of Veterans' Affairs
- 7 (d) medical practitioners; and
- 8 (e) Canadian Armed Forces outlets.

9 17. In the Province of Nova Scotia there are 176  
10 retail drug outlets, which, as will be seen from the map  
11 Exhibit "D", cover the entire Province. They are scat-  
12 tered from the largest cities to the smaller villages.  
13 In many cases the volume of prescription drug utiliza-  
14 tion would not in itself support, on an economic basis,  
15 a retail drug outlet. This requires the entrance into  
16 other fields of merchandising to subsidize the cost of  
17 operation. In other words, the "front store" must help  
18 support the dispensary.

19 18. There are 16 registered pharmaceutical chem-  
20 ists and 4 registered hospital pharmacists employed in  
21 hospitals in the Province. This assures pharmaceutical  
22 services to the majority of the larger hospitals. There  
23 is need, however, for more pharmacists in this field.  
24 There are 31 general hospitals in the Provinces depend-  
25 ing on the retail drug outlets for pharmaceutical ser-  
26 vices. It should be noted that in many cases this ser-  
27 vice has been donated by the pharmacists on a voluntary  
28 basis or at a small nominal fee.

29 19. Camp Hill Hospital, in Halifax is operated by  
30 the Department of Veterans Affairs. Drugs are distributed



Pharmaceutical services and drugs are provided to the people of Nova Scotia from the following

- (a) retail drug outlets;
- (b) hospital drug outlets;
- (c) Department of Veterans Affairs;
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In the Province of Nova Scotia there are 176 retail drug outlets, which, as will be seen from the map Exhibit "D", cover the entire Province. They are scattered from the largest cities to the smaller villages. In many cases the volume of prescription drug utilization would not in itself support, on an economic basis, a retail drug outlet. This requires the entrance into other fields of merchandising to subsidize the cost of operation. In other words, the "front store" must help support the dispensary.

There are 16 registered pharmaceutical chemists and 4 registered hospital pharmacists employed in hospitals in the Province. This assures pharmaceutical services to the majority of the larger hospitals. There is need, however, for more pharmacists in this field. There are 31 general hospitals in the Province depending on the retail drug outlets for pharmaceutical services. It should be noted that in many cases this service has been detected by the pharmacists on a voluntary basis or at a small nominal fee.

Camp Hill Hospital, in Halifax is operated by the Department of Veterans Affairs. Drugs are distributed



1 by its pharmacy department to persons qualifying for  
2 assistance.

3 20. ~~supply~~ In many of the more remote areas of the pro-  
4 vince a supply of drugs is maintained by the physician  
5 for immediate use of his patients. This method prevents  
6 delay in the commencing of medication to patients. It  
7 is a system used in areas where there is a sparse popu-  
8 lation. It might be noted that in recent years, as more  
9 retail drug outlets are established in these areas or  
10 closer to them, such a practice is diminishing.

11 21. ~~armed~~ The armed services of Canada maintain four  
12 registered pharmacists to provide pharmaceutical ser-  
13 vices to members of the armed forces stationed in Nova  
14 Scotia. This services is available to service personnel  
15 only, and not to their dependants, who must use the nor-  
16 mal retail drug outlets for their pharmaceutical services.

17 22. ~~at~~ Other methods of drug distribution have been  
18 tried in Nova Scotia. There was a doctors' clinic, a  
19 trade union clinic, and attempts to utilize hospitals  
20 for this purpose. These systems after a period of trial  
21 were found wanting. In most cases where such systems  
22 were tried, they have now returned to dispensing pharma-  
23 ceutical services and supplies, through the recognized  
24 and established channels listed in the preceding para-  
25 graphs.

26 23. ~~system~~ The Government of Nova Scotia, through its  
27 Department of Health, has instituted a system of supply-  
28 ing medication to diabetic patients who qualify for the  
29 service under a means test. The drugs are supplied  
30 through the normal retail drug outlets. This system of



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1 distribution is proving satisfactory. The patient has  
2 a readily available source of medication. He can be  
3 supplied with manageable small quantities more frequent-  
4 ly, thus lessening the storage problem since insulin,  
5 particularly, requires refrigeration, and should not be  
6 shipped any distance by mail.

7 24. ~~Service~~ There is need in Nova Scotia for more regis-  
8 tered pharmacists. The demand for pharmaceutical ser-  
9 vices is rapidly increasing. Year after year new drugs  
10 in increasing number are being added to our medical arm-  
11 ament. With this enormous increase in new and potent  
12 products which are available, and with the present in-  
13 creased participation in voluntary and contributory  
14 medical plans, there will be a corresponding increase  
15 in drug utilization. It should be noted, with satisfac-  
16 tion, that under the Nova Scotia hospitalization plan  
17 it was found in many hospitals where drug utilization  
18 was high, the length of patient stay was relatively  
19 speaking short. Thus active treatment hospital beds are  
20 being used to greater capacity due to the proper use of  
21 more advanced medication. With the increased utilization  
22 of radioactive isotopes in diagnostic and therapeutic  
23 treatment, an entirely new field is opened up. Training  
24 becomes necessary for the pharmacist to properly supply  
25 and control these drugs. In our hospitals there is a  
26 great need for well-qualified pharmacists, specializing  
27 in the developing fields of medicine. This need, from  
28 all indications, will become greater as progress con-  
29 tinues to be made in the field of research and applied  
30 medicine.



distribution is proving satisfactory. The patient has a readily available source of medication. He can be supplied with manageable small quantities more frequently, thus lessening the storage problem since he is particularly, reduces refrigeration, and should not be shipped any distance by mail.

24. There is need in Nova Scotia for more registered pharmacists. The demand for pharmaceutical services is rapidly increasing. Year after year new drugs in increasing number are being added to our medical armament. With this enormous increase in new and potent products which are available, and with the present increased participation in voluntary and contributory medical plans, there will be a corresponding increase in drug utilization. It should be noted, with satisfaction, that under the Nova Scotia hospitalization plan it was found in many hospitals where drug utilization was high, the length of patient stay was relatively

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25. It must be recognized that there is a great shortage of trained pharmacists in Nova Scotia. This applies in the following fields.

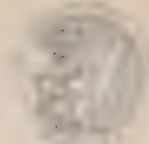
(a) In the retail pharmacy field while there is a definite shortage, it is difficult to estimate the extent of this shortage. The pharmaceutical services available at a retail drug outlet entail much more than filling doctors' prescriptions. It entails professional advices pertaining to many drug products which may be sold without prescription. As the Canadian Pharmaceutical Association has suggested this problem requires an extensive research program, including a study of the utilization and distribution of professional pharmaceutical talent.

(b) At present 20 registered pharmacists are employed in hospitals in Nova Scotia. There is an immediate need for at least fifteen more in this field, and the vigorous program of construction of new hospital beds will accentuate and aggravate the present shortage in the immediate future.

(c) There is no industrial manufacturing of drugs carried on in Nova Scotia at present. The Society submits that there is, however, a need for more graduates in pharmacy as representatives of the manufacturers in the Provinces, as it is largely through the well-trained medical detail man, that the active practitioners of medicine are made aware of the new and valuable results of research.

(d) It has been recognized by the Society that in order to be prepared to meet future demands,





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(d) It has been recognized by the Society that in order to be prepared to meet future demands



both qualitative and quantitative an expanded and advanced academic training program was needed. In answer to this need a new College of Pharmacy has been established at Dalhousie University within the new Faculty of Health Professions.

There are three main reasons for this increased need for pharmaceutical services:

(a) increase in population;

(b) increase in medication available

because of development in drug therapy;

and

(c) increase in medications used due to

increased availability of medical

services.

27. ~~entirely~~ The areas of study within term of reference

(c) which deals with the correlation of any new or improved program with existing services with a view to providing improved health care involves, first, the methods of effecting improvements and extensions of pharmaceutical services, and second, effects of implementing improvements and extensions of present methods of providing drugs and pharmaceutical services.

28. In studying the methods of effecting improvements and extensions of existing pharmaceutical services, the Society emphatically states its belief that the present method of distributing drugs and supply pharmaceutical services in Nova Scotia is appropriate. This does not mean that there is no logical reason for changing the method and and certainly no adequate and economical reasonable alternative is in sight. The Society realizes



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1 that the application of the method to changing conditions  
2 in Nova Scotia is not always perfect. There are cer-  
3 tainly some areas where coverage is not adequate, and  
4 fields of responsibility that should be developed fur-  
5 ther by the pharmacists. But let us build on what we  
6 have. Let us improve that which has served so well for  
7 so long and which has proved so adaptable to change and  
8 so capable of absorbing and translating progress into  
9 service to the public.

10 29. ~~29. 1950~~ We have pointed out that existing methods of  
11 supplying pharmaceutical services, through strategically  
12 located retail drug outlets, to the general public and  
13 through hospital pharmacies to their patients, with  
14 some minor improvements in location and staffing, are  
15 entirely adequate to provide a high standard of service,  
16 at reasonable cost, to the community, and we do not feel  
17 that there is need for any new, untried method of pro-  
18 viding such service. We are of the opinion that there  
19 is now a nucleus on which a greater service, with finan-  
20 cial help for certain categories of needy persons, can  
21 be established, and we feel that, with little additional  
22 cost, the present methods of distribution of drugs and  
23 other services can be improved and extended, and provide  
24 service to the public which will approach the ideal.  
25 Let us not sweep away what we have been wielding indis-  
26 criminately the knife of change. Let us build wisely  
27 on the experience tested system that we enjoy.

28 30. ~~30. 1950~~ While the matter of establishing priorities  
29 will be considered later on in this presentation, it  
30 might well be mentioned here that instituting a far



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1 reaching and complete drug benefit program could only  
2 be satisfactorily accomplished over a considerable  
3 period of time, with a demand far greater than supply,  
4 queues, even rationing, might result if a sudden change  
5 were made to allow comparatively unrestricted benefits.  
6 Adequate supplies and personnel must be on hand to meet  
7 the demand, and again we feel that the existing facilities  
8 and staff can most easily be expanded inline with  
9 a phased program, to provide a complete and satisfactory  
10 service.

11 31. Assuming that some agency will be prepared to  
12 assist persons who are incapable of providing drugs and  
13 pharmaceutical services from their own funds, it is  
14 quite possible, even likely, that small communities would  
15 be desirable areas for the establishment of a retail  
16 pharmacy. It is a fact that the so-called "front store"  
17 operation in retail pharmacy already subsidizes the professional  
18 department, and income from normal drug store  
19 sales, coupled with a fee for providing pharmaceutical  
20 services for persons in dire need, would, in our opinion,  
21 enable pharmacists to become established in areas which  
22 do not now have adequate pharmaceutical service. The  
23 effects of such an improved condition on the public are  
24 obvious. Prompt and efficient drug store services in a  
25 convenient location is not a luxury. The urban population  
26 of Canada is now receiving a very high standard of  
27 service for both chronic and acute conditions and, if at  
28 all possible, this service should be extended to those  
29 who now reside in rural areas.

30 32. The effect on the physician would also be a



reaching and complete drug benefit program could only be satisfactorily accomplished over a considerable period of time, with a demand far greater than supply. Quotas, even rationing, might result in a sudden change were made to allow comparatively unrestricted benefits adequate supplies and personnel must be on hand to meet the demand, and again we feel that the existing facilities and staff can most easily be expanded inline with a phased program, to provide a complete and satisfactory service.

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2 his patient a wider variety of items to choose from in  
3 the treatment of the condition. We must also point out  
4 that the true functions of the physician and the nurse  
5 are the practices of medicine and nursing, not the com-  
6 pounding and dispensing of medical prescriptions, or  
7 the purchase, storage, safeguarding and distribution of  
8 drugs in any form other than that required for immediate  
9 use of the patient. Indeed, we respectfully suggest  
10 that, should a comprehensive health plan be established  
11 at some future date, the work load of the physician  
12 and his assistants will be such that it will be impera-  
13 tive that they be relieved of the chore of distributing  
14 drugs, to devote their entire efforts to a field in  
15 which they are expert.

16 33. The experience of the Hospital Insurance Com-  
17 mission has shown that the addition of a pharmacist to  
18 the professional staff has resulted in a great admini-  
19 strative benefit to the hospital, as well as providing  
20 an economic benefit, in that the cost of drugs per patient  
21 per day usually decreases, due to expert handling of  
22 purchasing, preparing and distributing medical and  
23 therapeutic supplies. It is noteworthy also, that the  
24 hospital pharmacist is through training and experience,  
25 competent to act as a consultant to the physician and  
26 other members of the hospital staff - and this is again  
27 a definite and obvious aid in the efficient operation  
28 of the hospital.

29 34. The present and future requirements of person-  
30 nel to provide health services is the topic of term of  
of reference (d). This involves three things;



most valuable one, in that he would have available for his patient a wider variety of items to choose from in the treatment of the condition. We must also point out that the same functions of the physician and the nurse are the practices of medicine and nursing, not the compounding and dispensing of medical prescriptions, or the purchase, storage, safeguarding and distribution of drugs in any form other than that required for immediate use of the patient. Indeed, we respectfully suggest that, should a comprehensive health plan be established at some future date, the work load of the physician and his assistants will be such that it will be imperative that they be relieved of the chore of distributing drugs, to devote their entire efforts to a field in which they are expert.

The experience of the Hospital Insurance Commission has shown that the addition of a pharmacist to the professional staff has resulted in a great administrative benefit to the hospital, as well as providing an economic benefit, in that the cost of drugs per patient per day usually decreases, due to expert handling of purchasing, preparing and distributing medical and therapeutic supplies. It is noteworthy also, that the hospital pharmacist is through training and experience, competent to act as a consultant to the physician and other members of the hospital staff - and this is again a definite and obvious aid in the efficient operation of the hospital.

The present and future requirements of personnel to provide health services in the field of family





(a) present manpower status and requirements for professional pharmaceutical services in all areas of pharmacy including retail, hospital, industrial, educational, research and government services;

(b) present utilization of professional services of available pharmacists; and

(c) probable effect on pharmacy manpower requirements by increases in population, developments in drug therapy and requirements for possible extended services.

35. ~~Conclusion~~ The Society recognizes and emphasizes the crying need for adequate surveys to determine within the Province the present manpower status and requirements. The Society urges the Commission, with all the resources at its disposal to make the necessary study, and the Society pledges its whole-hearted co-operation.

36. ~~Conclusion~~ A study is already underway of the present utilization of professional services of available pharmacists and the Society respectfully reserves its opinion until such study is completed, analyzed and applied to existing conditions.

37. ~~Conclusion~~ A prognosis of requirement under foreseeable conditions is being made and again the Society reserves its opinion.

38. ~~Conclusion~~ Pharmacy education in Nova Scotia is presently undergoing extensive revision. The Canadian Conference of Pharmaceutical Faculties has suggested that a four year course based on senior matriculation should be the educational requirement for a pharmacist. In 1959



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38. Pharmacy education in Nova Scotia is presently undergoing extensive revision. The Canadian Conference of Pharmaceutical Societies has suggested that a four year course based on senior matriculation should be the educational requirement for a pharmacist. In 1941



1 an advisory committee appointed by the Canadian Confer-  
2 ence of Pharmaceutical Faculties and sponsored by the  
3 Canadian Foundation for the Advancement of Pharmacy  
4 visited the Maritime College of Pharmacy in Halifax and  
5 made recommendations regarding Pharmaceutical Education  
6 in the Maritimes. A copy of their report is submitted  
7 as Exhibit "H".

8 39. ~~Conclusion~~ At that time the training of pharmacists was  
9 the responsibility of the Maritime College of Pharmacy  
10 which was operated by the pharmacists of Nova Scotia,  
11 New Brunswick, and Prince Edward Island. The Maritime  
12 College of Pharmacy was founded in 1917 and incorporated  
13 by Chapter 80 of the Acts of Nova Scotia, 1940. This  
14 comprehensive report recommended that a four-year de-  
15 gree course based on senior matriculation should be  
16 introduced. It was further recommended that the train-  
17 ing of pharmacists should be the responsibility of a  
18 recognized University. At the present time an attempt  
19 is being made to implement the recommendations of this  
20 report. This summer the College of Pharmacy was incor-  
21 porated into Dalhousie University and this fall a new  
22 four-year course based on Junior matriculation was in-  
23 troduced. In order to completely implement the recom-  
24 mendations of the advisory committee additional finan-  
25 cial resources shall have to be provided. The pharma-  
26 cists of Nova Scotia and New Brunswick are presently  
27 providing substantial financial assistance for the Col-  
28 lege of Pharmacy. Additional revenue is obtained from  
29 provincial and federal governments. It is expected that  
30 the enrollment in the College of Pharmacy will increase







1 with the introduction of the new course.

2 40. In 1960-61 fifty-one students enrolled in the  
3 College of Pharmacy and the 1961-62 enrollment has  
4 risen to 78. The advisory committee recommend that to  
5 meet the future needs of the Maritime region, the total  
6 enrollment should reach 110. To accommodate this number,  
7 additional space and teaching personnel will have to be  
8 provided. This means that further financial assistance  
9 should be provided for the College of Pharmacy and that  
10 provincial and federal agencies should consider the  
11 possibility of increasing their financial assistance for  
12 the College of Pharmacy.

13 41. Term of reference (g) deals with the estimated  
14 cost of health services now being rendered to Canadians.  
15 with projected costs of any changes that may be recom-  
16 mended for the extension of existing programs or for  
17 any new programs suggested. This involves:

18 (a) types of drugs, medicinal preparations  
19 and therapeutic devices considered essential to  
20 the provision of quality health care;

21 (b) the present cost of providing drugs  
22 and pharmaceutical services considered necessary  
23 under study (a); and

24 (c) cost estimates for such new programs  
25 as might be suggested or contemplated in the  
26 course of the Commission's investigations.

27 42. This Society does not have the facilities or  
28 funds to make a study of the cost of prescription and  
29 drug services now being supplied to the people of this  
30 Province. We suggest that an estimate of the amount

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means to make a study of the cost of prescription and  
drug services now being supplied to the people of this  
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1 spent on prescribed drugs in retail stores could be  
2 obtained and presented to the Commission at a later  
3 date. An estimate of amounts spent by agencies, volun-  
4 tary and sponsored, government and other groups would  
5 be beyond our capabilities and we respectfully suggest  
6 that the Commission consider the acquiring of this in-  
7 formation as a vital research project, that it under-  
8 take the study with the full co-operation and assistance  
9 of the pharmacists of Nova Scotia.

10 43. Because we are not competent to determine  
11 what the essential health needs of the public are, we  
12 are not making specific suggestions regarding the assump-  
13 tion of costs of prescribed medicines and therapeutic  
14 devices by organizations, voluntary or sponsored, or  
15 by governments. We have pointed out that a segment of  
16 the population finds the cost of drugs a severe burden  
17 and we sincerely hope that the findings of this Commis-  
18 sion will result in some measure of relief being made  
19 available to this group. In this connection, the Com-  
20 mission and anybody charged with finding a solution to  
21 this problem, will receive the whole-hearted support  
22 and co-operation of the Nova Scotia Pharmaceutical  
23 Society.

24 44. At the same time, we must point out that  
25 experience has shown the provision of drugs, either  
26 on a free or contributory scheme, to be a most expen-  
27 sive undertaking. If government assumes the obligation  
28 to supply such items, it is obvious that the cost must  
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1 in other directions. Undoubtedly the Commission's  
2 study of the experience of other governments, including  
3 those of New Zealand and Great Britain will reveal that  
4 once a government paid for health plan is in operation  
5 the cost of providing prescribed drugs skyrocketed.  
6 This was illustrated in an article by T.M. Ross, 1961  
7 entitled "An Analysis of Pre-Payment of Prescriptions  
8 and the Green Shield Plan". At page 23 of the article,  
9 Mr. Ross points out:

10 "In New Zealand, where a government plan has  
11 been in effect since 1939, in the 17 year period  
12 from 1943 to 1960, the average prescription cost  
13 has increased from 44¢ to \$1.13 and the number of  
14 prescriptions per head of population has risen from  
15 2.1 to 5.9 per year. These two factors have com-  
16 bined to increase the average cost of prescriptions  
17 per person per year from 81¢ in 1943 to \$8.17 in  
18 1960.

19 "The National Health Service in Great Britain  
20 has focussed attention on the mounting costs of  
21 pharmaceutical services very frequently of late.  
22 In 1949/50, N.H.S. prescription figures showed an  
23 average of 5.29 prescriptions per year per person.  
24 This has remained remarkably constant through to  
25 1957/58. However, the average prescription price  
26 has increased from just over three shillings to  
27 just over six shillings in the same period of time.  
28 The frequency of prescribing remaining fairly con-  
29 stant may be a reflection of the fact that the N.  
30 H.S. found it necessary to raise the deterrent fee  
per prescription twice during this period."



in other directions. Undoubtedly the Government's study of the experience of other governments, including those of New Zealand and Great Britain will reveal the once a government paid for health plan is in operation the cost of providing prescribed drugs skyrocketed. This was illustrated in an article by T.M. Ross, 1961 entitled "An Analysis of Pre-Payment of Prescriptions and the Green Shield Plan". At page 23 of the article, Mr. Ross writes out:

"In New Zealand, where a government plan has been in effect since 1939, in the 17 year period from 1943 to 1960, the average prescription cost has increased from 14s to \$1.13 and the number of prescriptions per head of population has risen from 2.1 to 2.9 per year. These two factors have combined to increase the average cost of prescription per person per year from 81s in 1943 to \$8.17 in 1960.

"The National Health Service in Great Britain has focused attention on the mounting costs of pharmaceutical services very frequently of late. In 1950/51, N.H.S. prescription figures showed an average of 5.19 prescriptions per year per person. This has remained remarkably constant through to 1957/58. However, the average prescription price has increased from just over three shillings to just over six shillings in the same period of time. The frequency of prescribing remaining fairly constant may be a reflection of the fact that the N.H.S. found it necessary to raise the deterrent to over-prescription before this was done."



45.

There are many reasons for this high total cost, the most obvious being a condition which has become known as the "double-utilization rate". Briefly, this refers to the tendency on the part of the public to over utilize services which are either "free" or for which they pay through contributions or increased taxation. The patient visits the physician more often, resulting in an increase in the number of prescriptions written. At the same time, the physician, being aware of the fact that the patient is not going to be faced with having to pay for medication, is inclined to be generous in his estimate of the type and quantity required. It has been estimated (Green Shield Plan) that, whereas the cost of prescribed medication under present retail distribution methods per person is \$7.52, under the Insurance Plan, the per capita expense went to \$18.56.

46. ~~inter~~

Because of the extremely high cost of the National Health Service in Great Britain, Governments, since 1948, have in practice rejected the principle of meeting the full demand for free services. They have gone about this task of restriction in different ways, some designed to limit the cost of the service, others to shift the burden. They attempt to impose a ceiling on total expenditure to severely restrict capital construction, to exact charges for certain services, and by retaining wholly free services for special groups. They are also placing a larger proportion of the cost of medical services on social security funds. (John and Sylvia Jewkes, "A simple error in logic". Oct. 1961 "Fortune")

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Because of the extremely high cost of the services, many have in practice rejected the principle of meeting the full demand for free services. They have gone about this task of restriction in different ways, some designed to limit the cost of the service, others to shift the burden. They attempt to impose a ceiling on total expenditure to severely restrict capital contribution, to exact charges for certain services, and by retaining wholly free services for special groups. They are also placing a larger proportion of the cost of medical services on social security funds. (John and Sylvia Jewkes, "A simple error in logic", Oct. 1953)





1 47.

2 The struggle to keep down the cost to the  
3 British Government will be of special interest to this  
4 Commission. You are aware that all drugs were original-  
5 ly supplied to the public by National Health Service  
6 completely free of charge. To our knowledge, no other  
7 country in the western world provides drugs, either  
8 through voluntary insurance schemes or through the use  
9 of public funds, without restrictive conditions. Every  
10 British Government since 1948 has viewed with alarm the  
11 steadily mounting costs of drugs under National Health  
12 Service. Many measures have been imposed, including a  
13 steadily mounting "deterrent" fee, and many committees  
14 have reported on the problem (Hinchcliffe latest) Govern-  
15 ments have pleaded with the people to be considerate in  
16 their demands, they have set up extensive investigating  
17 bureaux to check on over-prescribing by physicians and,  
18 in so doing, interfere to some extent with professional  
19 independence and experiment. Price restrictions have  
20 been imposed on manufacturers of pharmaceuticals, and,  
21 in the process, research was discouraged. This has all  
22 led up to great inconvenience for the British people  
23 and more and more they are turning to private sources  
24 of supply - paying twice - once from their own pockets  
25 and again through taxation. In 1959 the British people  
26 spent more for privately purchased pharmaceuticals than  
27 did the National Health Services, (Jewkes), and the  
28 government is not meeting the full demand for free  
29 medical service. It would be regrettable if any govern-  
30 ment promised, or any other body advocated a plan,  
finding out too late that the plan was not economically  
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The struggle to keep down the cost to the British Government will be of special interest to this Commission. You are aware that all drugs were originally supplied to the public by National Health Service completely free of charge. To our knowledge, no other country in the western world provides drugs, either through voluntary insurance schemes or through the use of public funds, without restrictive conditions. Every British Government since 1948 has viewed with alarm the steadily mounting costs of drugs under National Health Service. Many measures have been imposed, including a steadily mounting "deterrent" fee, and many committees have reported on the problem (Minchcliffe latest). Governments have pleaded with the people to be considerate in their demands, they have set up extensive investigating bureaux to check on over-prescribing by physicians and, in so doing, interfere to some extent with professional independence and experiment. Price restrictions have been imposed on manufacturers of pharmaceuticals, and, in the process, research was discouraged. This has all led up to great inconvenience for the British people and more and more they are turning to private sources of supply - paying twice - once from their own pockets and again through taxation. In 1959 the British people spent more for privately purchased pharmaceuticals than did the National Health Service, (Jewkes), and the Government is not meeting the full demand for free medical service. It would be regrettable if any Government promised, or any other body advocated a plan, finding out too late that the plan was not economical.





1 48. Term of reference (h) concerns the methods of  
2 financing health care services as presently sponsored  
3 by management, labour, professional associations, in-  
4 surance companies or in any other manner. This involves  
5 a study of voluntary and sponsored Nova Scotian health  
6 care programs which now include drugs and pharmaceuti-  
7 cal services as benefits, and the suitability of expand-  
8 ing these programs, or some modification of them, as a  
9 general method of providing pharmaceutical services to  
10 the public.

11 49. The Society feels that this is a difficult  
12 matter to deal with on a provincial level as many  
13 schemes now in existence extend beyond the boundaries  
14 of the Province, and should be studied on a national,  
15 rather than a provincial basis. The Society will co-  
16 operate with the Canadian Pharmaceutical Association in  
17 such a study, and anticipates that the Association  
18 will be making a comprehensive submission to the Com-  
19 mission on this at a later date. Appendix "F" deals  
20 with Municipal Participation in health programs and the  
21 care of Indigents.

22 50. An interesting project exists in the Halifax  
23 area. This is the Halifax Visiting Dispensary. Ap-  
24 pendix "G" deals in greater detail with the operation  
25 of this dispensary. Its 1959 annual report is submit-  
26 ted as Exhibit "F".

27 51. Term of reference (j) deals with the relation-  
28 ship of existing and any recommended health care pro-  
29 grams with medical research and the means of encourag-  
30 ing a high rate of scientific development in the field





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2 topic is an appropriate one for the Canadian Conference  
3 of Pharmaceutical Faculties to deal with, and expects  
4 that it will do so.

5 52. ~~Improvement~~ Term of reference (k) deals with the feasibil-  
6 ity and desirability of priorities in the development  
7 of health care services. This raises the following  
8 problems for study.

9 (a) determination of the individual and  
10 family expenditures on drugs, and whether a  
11 high proportion of drug costs are born by a  
12 relatively small proportion of the population,  
13 and if so, why;

14 (b) possible definition of groups to whom  
15 the cost of drugs represent a significant financial  
16 problem.

17 (c) if the previous study shows that well  
18 defined groups incurring abnormally high drug  
19 costs do exist, suggestions for priorities within  
20 a drug assistance program which would alleviate  
21 these cases of most urgent need; and

22 (d) determination of stages in the develop-  
23 ment of comprehensive health care services pro-  
24 grams in priority stages according to type or area  
25 of service and in keeping with conclusions establish-  
26 ed in the above studies.

27 53. The need for extensive research here is ob-  
28 vious. Recommendations not based on the results of such  
29 research would be of little value. Only rules of thumb  
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vious. Recommendations not based on the results of such research would be of little value. Only rules of thumb can be used at present and they are of doubtful value.





One such rule is that approximately 65% of drug costs are paid by 13% of the population.

54. Under term of reference (1) - such other matters as the Commissioners deem appropriate for the improvement of health services to all Canadians - the Canadian Pharmaceutical Association has suggested three study areas:

(a) health service programs in other countries which include drugs and pharmaceutical services among their benefits;

(b) experience of such programs in utilization of drugs and pharmaceutical services; and

(c) proportion of total health care costs in such programs represented by drugs and pharmaceutical services.

55. The Society endorses the recommendation of these study areas and urges that the Commission proceed with such studies.

56. The Society also recommends to the Commission the following research projects:

(a) pharmacy manpower;

(b) present and projected costs of drugs and pharmaceutical services in the Province;

(c) family and individual expenditure patterns for drugs and pharmaceutical services;

and

(d) historical experience of health care programs in foreign countries.

Detailed outlines of these proposed studies indicating their scope and nature are attached to the preliminary

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statement of the Canadian Pharmaceutical Society as  
Appendices "D", "E" and "F".

57. The Society is ready to expand its study of  
the provincial field upon the request of the Royal  
Commission, within its resources to do so, either now  
or at a later date. It hopes that if such request is  
made sufficient time will be allowed in which to com-  
plete the study.

58. The Society feels that the Commission will,  
during the course of its studies require expert opinion  
on portions of submissions dealing with the professional  
and technical aspects of pharmacy. The Society strong-  
ly submits that only a pharmacist can provide such expert  
opinion. The medical practitioners appointed to the  
Commission and the medical consultant engaged to assist  
the Commission undoubtedly possess great knowledge of  
the clinical application of drugs. But it is respect-  
fully proposed that, outside of the fields of clinical  
application and therapeutic effectiveness of drugs,  
these able men possess no special competence in the  
professional and technical aspects of pharmacy and their  
opinions in these areas cannot be accepted as expert  
by this Society.

59. Because of the absence of a pharmacist on the  
Commission, and the unquestionable requirement for ex-  
pert advice by the Commission on specialized areas of  
the practice of pharmacy, it is urged that a pharmacy  
consultant be appointed without further delay to assist  
the Commission. The Society believes that such an  
appointment would contribute greatly to the effective-  
ness of the Commission's work.





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60. Attention is directed to Appendix "H" which reviews the Society's statement of Policy Relative to Health Care Plans, and to Appendix "I" which deals with the problem of "Drug Nomenclature" - "Brand Name vs Generic Name".

61. In conclusion we would like to draw attention to a paragraph contained in the "Financial Report of the Committee on the Cost of Prescribing" Chaired by Sir Henry Hinchcliffe. This report is available from Her Majesty's Stationery Office, 1959, London, England. The paragraph referred to is contained in the financial statement and summary of the report and reads as follows:

"There is no satisfactory alternative to the present system of supplying National Health Services medicines through the established retail channels. If purchase and distribution of medicines were undertaken centrally or through health centers, costs would increase".

All of which is respectfully submitted.

.....

Dated at Halifax, Nova Scotia  
this 1st day of October, A.D. 1961

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APPENDIX "A"

to Submission by the  
Nova Scotia Pharmaceutical  
Society

Summary of Provisions of the  
Pharmacy Act

R.S.N.S. (1954) Chapter 216

as amended by

Acts of 1957 Chapter 37

Note: this is a summary only.

Reference to the complete text

of the Act is urged where necessary.

A.1. By the interpretation section (Sec. 1) the Act  
defines

- (a) "certified clerk" as a person registered as  
such under Section 16;
- (b) "hospital pharmacist" as a person registered  
as such under the Act;
- (c) "pharmaceutical chemist" as a person registered  
as such under the Act;
- (d) "wholesale pharmacist" as a person registered  
as such under the Act.

A.2. Section 2 continues the Nova Scotia Pharma-  
ceutical Society as a body corporate consisting of such  
persons who are now members thereof together with such  
persons as shall hereafter pursuant to the Act become  
members and whose names shall be entered on the Society's  
register.

A.3. The Society has power to hold and deal with  
real and personal property and to erect buildings for  
the accommodation of its members. (Section 3).

A.4. The Council of the Society consists of 12  
members who shall conduct the affairs and exercise the

to Submission by the  
Scottish Pharmaceutical  
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members who shall conduct the affairs and exercise the



1 powers of the Society, subject to the directions of any  
2 special or general meeting of the Society. Members  
3 of the Council are elected for a term of two years, one  
4 half each year. (Section 4 (3)). Only registered mem-  
5 bers of the Society are entitled to vote.

6 A.5. The Council elects the officers of the Society  
7 from among its members. The officers are a President,  
8 Vice-President, Secretary and Treasurer. The Council  
9 appoints a Registrar. (Section 5). The Council, sub-  
10 ject to approval by the Governor-in-Council may make  
11 by-laws and regulations concerning (Section 7):

- 12 (a) examination of candidates for registra-  
13 tion under the Act;
- 14 (b) fees payable under the Act;
- 15 (c) appointment, remuneration and definition  
16 of duties of officers and examiners under  
17 the Act;
- 18 (d) meetings of the Society and Council;
- 19 (e) Regulation of the terms and conditions  
20 upon which certificates of registration  
21 may be issued or revoked; and
- 22 (f) other matters requisite for the carrying  
23 out the Act.

24 A copy of the Society's regulations is submitted as  
25 Exhibit "B". The Council has the control and manage-  
26 ment of the real and personal property of the Society  
27 (Section 6).

28 A.6. A Board of Examiners is established by Sec-  
29 tion 8 of the Act. One half of the Board is appointed  
30 by the Governor-in-Council and the remainder by Council.  
Appointments are for a three year term. The number of  
members is determined by by-law (Section 8).

A.7. The examination of candidates for registra-





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A.7. The examination of candidates for registra-



tion under the Act is held at least once a year by the Board of Examiners. Upon the Board's report to Council that any candidate has passed the prescribed examinations, the Registrar shall sign and issue the requisite diploma (Section 9). There are four classes of examinations:

- (a) for registration as certified clerks;
- (b) for registration as pharmaceutical chemists;
- (c) for registration as hospital pharmacists; and
- (d) for registration as wholesale pharmacists.

A.8. ~~Registered~~ Before any candidate is entitled to be registered as a certified clerk he shall produce to Council satisfactory evidence of good moral character and that he has conformed to the requirements prescribed in the regulations for examination under this Act. (Section 11).

A.9. ~~the~~ A candidate desiring to be examined for registration as a pharmaceutical chemist shall produce to the Council satisfactory evidence that he has passed all other prescribed examinations or been exempted therefrom, that he has served as clerk or assistant to a registered pharmaceutical or hospital pharmacist for not less than four years and that during at least two of these years he has been registered under this Act as a certified clerk (or has on special application to the Council been exempted from such registration) and has during two years actually been employed in dispensing or compounding prescriptions. Similar provisions govern the qualification for registration of hospital pharmacists (Section 12).

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- (b) for registration as pharmaceutical chemist;
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- (d) for registration as wholesale pharmacist.

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1 A.10. A candidate desiring to be examined for regi-  
2 stration under this Act as a wholesale pharmacist shall  
3 produce to the Council satisfactory evidence that he  
4 has been registered under this Act as a certified clerk  
5 and that he has passed all required examinations of the  
6 diploma or degree courses of the Maritime College of  
7 Pharmacy. (Section 12).

8 A.11. Every person who passes the examination for  
9 registration and complies with the regulations of Coun-  
10 cil shall on payment of the prescribed fees be entitled  
11 to a diploma and to have his name entered upon the  
12 register of the Society under the appropriate category.  
13 (Section 13).

14 A.12. The Council has a discretion to accept the  
15 diploma or certificate of a competent examining board  
16 outside Nova Scotia as sufficient existence of quali-  
17 fication of any applicant to be registered as a member  
18 of the Society. (Section 13).

19 A.13. A candidate for registration as a pharmaceu-  
20 tical chemist must be at least 21 years of age and a  
21 Canadian citizen.

22 A.14. Every member of the Society (with a minor  
23 exception) shall pay to the Registrar a yearly fee,  
24 not exceeding \$100.00, determined by Council, and upon  
25 such payment and upon complying with the by-laws re-  
26 specting registration, shall receive a certificate  
27 operative for the remainder of the calendar year. Upon  
28 failure so to do, a member forfeits his place on the  
29 register of the Society and ceases to be a member there-  
30 of. His name may be replaced at the discretion of Coun-



A.10. A candidate desiring to be examined for registration under this Act as a wholesale pharmacist shall produce to the Council satisfactory evidence that he has been registered under this Act as a certified chemist and that he has passed all required examinations of the diploma or degree courses of the Maritime College of Pharmacy. (Section 12).

A.11. Every person who passes the examination for registration and complies with the regulations of Council shall on payment of the prescribed fees be entitled to a diploma and to have his name entered upon the register of the Society under the appropriate category. (Section 13).

A.12. The Council has a discretion to accept the diploma or certificate of a competent examining board outside Nova Scotia as sufficient evidence of qualification of any applicant to be registered as a member of the Society. (Section 13).

A.13. A candidate for registration as a pharmacist must be at least 21 years of age and a Canadian citizen.

A.14. Every member of the Society (with a minor exception) shall pay to the Society a subscription not exceeding \$100.00, determined by Council, and upon such payment and upon complying with the by-laws respecting registration, shall receive a certificate operative for the remainder of the calendar year. Upon failure so to do, a member forfeits his place on the register of the Society and ceases to be a member thereof. His name may be replaced at the discretion of Council.





1 cil upon payment of arrears of fees. No person shall  
2 be entitled to any of the privileges of a pharmaceutical  
3 chemist, hospital pharmacist, a wholesale pharmacist  
4 under the Act who is in default of fees (Section 14).

5 A.15. Every certified clerk shall pay an annual  
6 fee, not exceeding \$10.00, as Council determines to the  
7 Registrar. There are similar provisions dealing with  
8 default. (Section 14).

9 A.16. Every duly qualified medical practitioner  
10 registered as a pharmaceutical chemist under this Act  
11 on the 30th day of May, 1921, shall be entitled to be  
12 so-registered from year to year. This is a "hang-over"  
13 provision, and there are no persons registered under it  
14 at present. Medical practitioners shall not be re-  
15 quired to take further instructions or to pass examina-  
16 tions in subjects in which they have passed equivalent  
17 examinations in their medical course. (Section 15).

18 A.17. The Registrar shall keep a register of members  
19 of the Society. A copy is deposited each year in the  
20 office of the Provincial Secretary. The list is publi-  
21 shed as Council directs, and copies may be obtained  
22 from the Registrar without charge. The Registrar also  
23 keeps a register of certified clerks. He issues cer-  
24 tificates of registration under the seal of the Society  
25 to persons entitled thereto. (Section 16).

26 A.18. Section 17 prohibits the sale of certain  
27 articles except by members of the Society or certified  
28 clerks under their supervision. These articles are the  
29 poisons, drugs and medicines included in Schedule A to  
30 the Act, unless the sale is expressly authorized in



all upon payment of arrears of fees. No person shall be entitled to any of the privileges of a pharmacist, chemist, hospital pharmacist, a wholesale pharmacist, under the Act who is in default of fees (Section 14).

A.15. Every certified clerk shall pay an annual fee, not exceeding \$10.00, as Council determines to be Registrar. There are similar provisions dealing with

A.16. Every duly qualified medical practitioner registered as a pharmaceutical chemist under this Act on the 30th day of May, 1921, shall be entitled to be so registered from year to year. This is a "hang-over" provision, and there are no persons registered under it at present. Medical practitioners shall not be required to take further instructions or to pass examinations in subjects in which they have passed equivalent examinations in their medical course. (Section 15.)

A.17. The Registrar shall keep a register of members of the Society. A copy is deposited each year in the office of the Provincial Secretary. The list is published as Council directs, and copies may be obtained from the Registrar without charge. The Registrar also keeps a register of certified clerks. He issues certificates of registration under the seal of the Society to persons entitled thereto. (Section 16.)

A.18. Section 17 prohibits the sale of certain articles except by members of the Society or certified clerks under their supervision. These articles are the poisons, drugs and medicines included in Schedule A to the Act, unless the sale is expressly authorized in



1 Schedule A and then only upon the conditions set out  
2 in Schedule A. The Section also restricts the compound-  
3 ing or dispensing of drugs for medicinal purposes to  
4 persons who are pharmaceutical chemists or certified  
5 clerks under the supervision and in the employ of a  
6 pharmaceutical chemist, or to hospital pharmacists or  
7 certified clerks in the employ of a hospital and under  
8 the supervision of a hospital pharmacist.

9 A.19. Section 18 deals with the conduct of shops  
10 for the compounding of drugs or medicines. Such shops  
11 shall be under the personal superintendence of, and  
12 shall be bona fide conducted by a pharmaceutical chem-  
13 ist. Branches of any such shop must be under the per-  
14 sonal superintendence and bona fide conduct of another  
15 pharmaceutical chemist. Every such shop shall be con-  
16 ducted under the name of the pharmaceutical chemist who  
17 shall be the proprietor thereof, and his name (and the  
18 name of the Manager if applicable) shall be publicly  
19 displayed on the premises. Any proprietor however,  
20 may conduct his business under a firm name, adding,  
21 however, his own name as proprietor. A pharmaceutical  
22 chemist doing business shall display his annual certi-  
23 ficate as a pharmaceutical chemist in a public and  
24 conspicuous place where he carries on business.

25 A.20. Section 20, with certain exceptions, restricts  
26 the conduct of certain business to registered pharma-  
27 ceutical chemists. No person shall sell or attempt to  
28 sell, or expose for sale, or dispense or compound for  
29 sale or keep open shop for selling, dispensing or com-  
30 pounding poisons drugs or medicines, or sell or keep



Schedule A and then only upon the conditions set out in Schedule A. The Section also restricts the compounding or dispensing of drugs for medicinal purposes to persons who are pharmaceutical chemists or certified clerks under the supervision and in the employ of a pharmaceutical chemist, or to hospital pharmacists or certified clerks in the employ of a hospital and under the supervision of a hospital pharmacist.

A.19. Section 19 deals with the conduct of shops

for the compounding of drugs or medicines. Such shops shall be under the personal superintendence of, and shall be bona fide conducted by a pharmaceutical chemist. Branches of any such shop must be under the personal superintendence and bona fide conduct of another pharmaceutical chemist. Every such shop shall be conducted under the name of the pharmaceutical chemist who shall be the proprietor thereof, and his name (and the name of the Manager if applicable) shall be publicly displayed on the premises. Any proprietor however, may conduct his business under a firm name, adding, however, his own name as proprietor. A pharmaceutical chemist doing business shall display his annual certificate as a pharmaceutical chemist in a public and conspicuous place where he carries on business.

A.20. Section 20, which contains exceptions, restricts

the conduct of certain business to registered pharmaceutical chemists. No person shall sell or attempt to sell, or expose for sale, or dispense or compound for sale or keep open shop for selling, dispensing or compounding poisons, drugs or medicines, or sell or keep





1 for sale or attempt to sell any of the articles men-  
2 tioned in Schedule A (Schedule A may be amended or  
3 added to by authority of the Governor-in-Council upon  
4 recommendation of the Council), unless the sale is  
5 expressly authorized in Schedule A and then only upon  
6 the conditions therein set out.

7 A.21. Section 20 also states that no person shall  
8 assume or use the title of chemist and druggist, or  
9 chemist or druggist or pharmacist or pharmaceutist, or  
10 pharmaceutical chemist or apothecary, or dispensing  
11 chemist or dispensing druggist, or any sign, title or  
12 advertisement implying or calculated to lead people  
13 to infer or believe that he is a pharmaceutical chem-  
14 ist registered under this Act, or shall call his place  
15 of business in Nova Scotia a "drug store" or "pharmacy",  
16 unless the person is registered as a pharmaceutical  
17 chemist under this Act, and holds a valid certificate  
18 of registration as a pharmaceutical chemist under the  
19 Act.

20 A.22. The provisions of Section 20 respecting sel-  
21 ling, dispensing or compounding do not apply to certified  
22 clerks while acting in the employ of a pharmaceutical  
23 chemist.

24 A.23. Section 20 does not prevent any person not  
25 registered under the Act from selling aspirin tablets  
26 in sealed packages, carbolic acid in sealed bottles,  
27 tincture of iodine in sealed bottles, quinine tablets  
28 and formaldehyde for treating seed-grain, and for disin-  
29 fecting purposes, in any polling district which is not  
30 within the limits of a city or incorporated town, or in



for sale or attempt to sell any of the articles mentioned in Schedule A (Schedule A may be amended or added to by authority of the Governor-in-Council upon recommendation of the Council), unless the sale is expressly authorized in Schedule A and then only upon the conditions therein set out.

A.21. Section 20 also states that no person shall

assume or use the title of chemist and druggist, or chemist or druggist or pharmacist or pharmaceutical chemist or dispensing druggist, or any other title or advertisement implying or calculated to lead people to infer or believe that he is a pharmaceutical chemist registered under this Act, or shall call his place of business in Nova Scotia a "drug store" or "pharmacy" unless the person is registered as a pharmaceutical chemist under this Act, and holds a valid certificate of registration as a pharmaceutical chemist under this

A.22. The provisions of Section 20 respecting selling, dispensing or compounding do not apply to certified clerks while acting in the employ of a pharmaceutical

A.23. Section 20 does not prevent any person not registered under the Act from selling against tablets in sealed packages, carbolic acids in sealed bottles, tincture of iodine in sealed bottles, painting tablets and formaldehydes for treating seed-grain, and for disinfecting purposes, in any polling district which is not within the limits of a city or incorporated town, or in



1 which there is no registered pharmaceutical chemist  
2 carrying on business.

3 A.24. The provisions of Section 20 apply to an  
4 incorporated company, which is deemed to be a person  
5 under the Section, unless a majority of its directors  
6 are duly registered as pharmaceutical chemists and  
7 unless one of such directors who is a pharmaceutical  
8 chemist shall personally manage, superintend and bona  
9 fide conduct the shop, and shall have his name and  
10 certificate displayed therein.

11 A.25. Restrictions on the sale of poisons are laid  
12 down in Section 21. No person shall sell any poison  
13 named in Schedule A, which said poisons Schedule A ex-  
14 pressly declares may only be sold by a registered phar-  
15 maceutical chemist who shall record each sale in the  
16 poison register, unless the box, bottle, vessel, wrapper,  
17 or cover in which the poison is contained is distinct-  
18 ly labelled with the name of the article and the word  
19 "poison" and if sold by retail, then also with the  
20 name and address of the proprietor of the establishment  
21 in which the poison is sold, and unless on every sale  
22 of any such article the person actually selling the  
23 same, shall before delivery, make an entry in a book  
24 in the form set out in Schedule B (the register of  
25 poisons) attesting the date of the sale, the name and  
26 address of the purchaser, the name and quantity of the  
27 article sold, and the purpose for which it is stated  
28 by the purchaser, to be required, to which entry the  
29 signature of the purchaser and of the person actually  
30 selling the same shall be affixed. The poison register



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A.24. The provisions of Section 20 apply to an

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pressly declares may only be sold by a registered phar-  
macutical chemist who shall record each sale in the  
poison register, unless the box, bottle, vessel, wrapper,  
or cover in which the poison is contained is distinctly  
labelled with the name of the article and the word  
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selling the same shall be affixed. The poison register



1 is open for inspection by an officer of the Society,  
2 a member of the Royal Canadian Mounted Police, or a  
3 judge or magistrate or person appointed by him.

4 A.26. The Council may by resolution add to or re-  
5 move poisons, dangerous drugs, or medicines from Sched-  
6 ule A, and determine the conditions under which such  
7 articles may be sold. No such resolution shall have  
8 effect until approved by the Governor-in-Council and  
9 published in the Royal Gazette for one month. (Sec-  
10 tion 22).

11 A.27. The Act does not prevent a person from sell-  
12 ing goods of any kind to any duly qualified medical  
13 practitioner, dentist or veterinary surgeon, nor the  
14 supplying by members of such professions to their  
15 patients such medicines as they may require. (Section  
16 23).

17 A.28. Every laboratory in which drugs or medicines  
18 are compounded for sale, either by retail or wholesale,  
19 and the shipping or delivery of poisons, dangerous  
20 drugs or medicines from any wholesale warehouse shall  
21 be under the personal superintendence of a registered  
22 pharmaceutical chemist or wholesale pharmacist. (Sec-  
23 tion 23).

24 A.29. Nothing in the Act prevents the sale of  
25 "patent medicines" provided that they do not contain  
26 any Schedule A drugs (Section 23).

27 A.30. The Act contains sanctions against misrepre-  
28 sentation (Section 24) and sections dealing with en-  
29 forcement, burden of proof and penalties (See Sec-  
30 tions 25 and 26).



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any Schedule A drugs (Section 23).

Section 24) and sections dealing with en-  
forcement, burden of proof and penalties (Sec 25-  
tions 26 and 27).





1 A.31. Section 27 gives to every person who presents  
2 a prescription to a pharmaceutical chemist to be filled  
3 the right to have a copy furnished to him, unless other-  
4 wise directed by the medical practitioner prescribing  
5 the same. The original prescription is to be retained  
6 by the pharmaceutical chemist.

7 A.32. Finally, Section 29 provides that no person  
8 selling articles in violation of the Act shall recover  
9 the amount of any charges in respect thereof in any  
10 court of justice.



A.31. Section 27 gives to every person who presents a prescription to a pharmaceutical chemist to be filled the right to have a copy furnished to him, unless otherwise directed by the medical practitioner prescribing the same. The original prescription is to be retained by the pharmaceutical chemist.

A.32. Finally, Section 29 provides that no person selling articles in violation of the Act shall recover the amount of any charges in respect thereof in any court of justice.



APPENDIX "B"

to Submission by  
the Nova Scotia Pharmaceutical  
Society

INTERPRETATION OF CERTAIN TERMS USED

IN SOCIETY'S SUBMISSION

B1 The following definitions are presented to the Commission to ensure a uniform interpretation of these terms as they are used in this statement, and in any future submissions made by the Society.

B2 The interpretation of "pharmacy" and "pharmacist" submitted by the Canadian Pharmaceutical Association in its preliminary statement to the Commission is adopted by the Society, and will be used throughout its submissions. Reference is made in this regard to Appendix "B" of the preliminary statement of the Canadian Pharmaceutical Association.

B3 The following words are to be interpreted as set out below:

(a) "Act" means the Pharmacy Act, Chapter 216 of the Revised Statutes of Nova Scotia, 1954, as amended by Chapter 37 of the Acts of Nova Scotia, 1957.

(b) "Society" means the Nova Scotia Pharmaceutical Society, and words such as President, Council, Registry, by-laws, regulations, etc., mean those of the Society unless otherwise noted.

(c) "pharmaceutical chemist" means a member of the Society registered under the Act as a pharmaceutical chemist.

(d) "hospital pharmacist" means a member of





to Submission by  
Society

# IN SOCIETY'S SUBMISSION

The following definitions are presented to the Commission to ensure a uniform interpretation of these terms as they are used in this statement, and in any future submissions made by the Society.

The interpretation of "pharmacy" and "pharmacist" submitted by the Canadian Pharmaceutical Association in its preliminary statement to the Commission is adopted by the Society, and will be used throughout its submissions. Reference is made in this regard to Appendix "B" of the preliminary statement of the Canadian

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as amended by Chapter 37 of the Acts of Nova Scotia,

(b) "Society" means the Nova Scotia Pharmas-

eutical Society, and words such as President, Coun-

cil, Registrar, by-laws, regulations, etc., mean

those of the Society unless otherwise noted.

(c) "Pharmaceutical chemist" means a member

of the Society registered under the Act as a phar-

maceutical chemist.

(d) "Hospital pharmacist" means a member of



1 the Society registered under the Act as a hospital  
2 pharmacist.

3 (e) "wholesale pharmacist" means member of  
4 the Society registered under the Act as a wholesale  
5 pharmacist.

6 (f) "certified clerk" means a person register-  
7 ed as a certified clerk under the provisions of the  
8 Act.

9 (g) "retail drug outlet" means a shop or  
10 place of business where poisons, drugs or medicines  
11 are sold or exposed for sale to the general public.

12 (h) "wholesale drug outlet" means a shop or  
13 place of business where poisons, drugs or medicines  
14 are sold or exposed for sale in the ordinary course  
15 of wholesale dealing.

16 (i) "hospital drug outlet" means an institu-  
17 tion or establishment where poisons, drugs or medi-  
18 cines are dispensed to patients in the institution  
19 or establishment or to outpatients at the institu-  
20 tion or establishment.

21  
22  
23  
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26  
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30



the Society registered under the Act as a hospital

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the Society registered under the Act as a wholesale

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of wholesale dealing.

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or establishment where poisons, drugs or medicine

are dispensed to patients in the institution

or establishment or to outpatients at the institution

or establishment.





APPENDIX "C"

to the Submission

of the Nova Scotia Pharmaceutical

Society

Maritime College of Pharmacy

C1 Beginning in 1908 and ending in the Spring of 1911, evening classes in chemistry and pharmacy were conducted by a group of pharmacists in the Nova Scotia Technical College in Halifax. The success of these classes encouraged the Society with the aid of and in affiliation with Dalhousie University, to establish The Nova Scotia College of Pharmacy in 1911. The aim of the college was to provide pharmaceutical education for students in the Atlantic area.

C2. In May 1916, at the request of the Society, a course for clerks was initiated. This course having proved its educational worth was further developed and became known as the Elementary Pharmacy Course, an integral part of the College curriculum. From 1925 until its discontinuance in 1961 it was a prerequisite to other courses offered by the College.

C3 In June 1917, The New Brunswick Pharmaceutical Society joined with The Society in the operation of the College, and the name was changed to Maritime College of Pharmacy.

C4 The Maritime College of Pharmacy was incorporated by Chapter 80 of the Acts of Nova Scotia, 1940. A copy of the Act and the By-laws is submitted as Exhibit "E".

C5 In July 1950 The Prince Edward Island Pharmaceutical Association was admitted to affiliation with the College.

05 In July 1950 the Prince Edward Island Pharmacy

04 A copy of the Act and the By-Laws is submitted as Ex-  
hibited "B".  
The Maritime College of Pharmacy was incor-  
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Beginning in 1908 and ending in the Spring

Maritime College of Pharmacy  
Society  
of the Nova Scotia Pharmaceutical  
to the Submission



C6                    The affairs of the College were directed by  
a Board of Trustees comprised or representation from  
Dalhousie University and the provincial pharmaceutical  
bodies of the Maritimes.

C7                    This arrangement continued until a short  
time ago when under the terms of an agreement dated  
the 3rd day of August 1961, The Maritime College of  
Pharmacy became an integral part of Dalhousie Univer-  
sity and the latter institution has assumed responsi-  
bility for providing an improved course for students  
in pharmacy. The Maritime College of Pharmacy exists  
today in name only.





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a Board of Trustees comprised or representation from  
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07

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time ago when under the terms of an agreement dated  
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in pharmacy. The Maritime College of Pharmacy exists  
today in name only.



APPENDIX "D"

to the Submission  
of the Nova Scotia Pharmaceutical  
Society

Officers of the Nova Scotia Pharmaceutical Society

PRESIDENT	Mr. Douglas A. Stallard, New Glasgow, N.S.
VICE-PRESIDENT	Robert G. Crowell, 18 Norwood St. Halifax, N.S.
TREASURER	Robert W. Zinck, Hantsport, N.S.
SECRETARY-REGISTRAR	J. Esmonde Cooke, 28 Joseph St., Halifax, N.S.

MEMBERS OF COUNCIL: (The above plus

Lawrence Perry, 83 George Dauphinee Ave., Halifax,  
N.S.

J. Keith Lawton, 963 Greenwood Ave., Halifax, N.S.

William H. Manson, Sydney, N.S.

W. Stewart Sterns, Glace Bay, N.S.

John MacKinnon, Antigonish, N.S.

Cecil C. Fulton, Tatamagouche, N.S.

William F. Mooney, Yarmouth, N.S.

C. Douglas Hemeon, Liverpool, N.S.

Solicitor A.W. Cox, 223 Hollis St., Halifax, N.S.

Inspector J.P. Blakeney, Windsor, N.S.



to the Submission  
of the Nova Scotia Pharmaceutical  
Society

Mr. Douglas A. Stelford, New Glasgow

PRESIDENT

Robert W. Sime, Hantsport, N.S.  
Hallifax, N.S.

TREASURER

MEMBERS OF COUNCIL: (The above plus)

Lawrence Perry, 83 George Dauphine Ave., Hallifax,  
N.S.

William H. Menon, Sydney, N.S.

John MacKinnon, Antigonish, N.S.

Geoff C. Patton, Tatamagouche, N.S.

Collector A.W. Cox, 223 Hollis St., Hallifax, N.S.





APPENDIX "E"

to Submission by the  
Nova Scotia Pharmaceutical  
Society

AREAS AND PROBLEMS PERTAINING TO PHARMACY

IN NOVA SCOTIA

SUGGESTED FOR STUDY OF THE ROYAL COMMISSION

ON HEALTH SERVICES

E1 The purpose of this Appendix is to give more detail to the Commission on some of the suggested areas and problems for study by it.

E2 Present Methods of Providing Drugs and Pharmaceutical Services

This area of study should include all operations concerned with the production, distribution and sale of drugs. The following broad outline is suggested with comments relating specifically to Nova Scotia.

(a) The manufacture of basic drugs and chemicals. Little such manufacture, if any, is carried on in Nova Scotia; this Province is affected by the picture in the Canadian industry generally, and by foreign sources of supply.

(b) The manufacture and sale of pharmaceutical preparations. Comments made under (a) apply equally here.

(c) The wholesale drug industry; warehousing and distribution. In Nova Scotia manpower, distance from sources of supply, and transportation costs merit particular attention.

APPENDIX "E"

to Submission by the

Commission on the

Subject

THE COMMISSION ON THE

Subject

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(b) The manufacture and sale of pharmaceutical

preparations. Comments made under (a) apply

equally here.

(c) The wholesale drug industry; warehousing

and distribution. In Nova Scotia manpower,

distance from sources of supply, and

transportation costs merit particular atten-



(d) Provision of drugs and pharmaceutical services through retail drug outlets. Lack of detailed statistical information reduced to Provincial levels is a handicap. The Society urges the Commission to undertake the necessary research to remove this limitation and offers its assistance within the bounds of its resources.

(e) Distribution of drugs and pharmaceutical services through hospital drug outlets. The limitations mentioned in (d) should not apply here. The Hospital Insurance Commission should have the necessary information available to form an accurate base for investigation and study by the Commission.

E3 Deficiencies in Present Methods of Providing Drugs and Pharmaceutical Services

It is probable that the health professions closely associated with Pharmacy and the public receiving pharmaceutical services will point out to the Commission deficiencies in present services. These must be faced frankly by the Society which will endeavour to deal with them realistically. We are confident that the Commission will restrict its considerations to factual submissions and will deal with emotional and unfounded complaints in the manner they deserve.

E4 There are two types of deficiencies:

(a) Qualitative, that is professional functions which are not being performed adequately, and additional professional functions which might be assumed by pharmacy



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### Deficiencies in Present Methods of Providing Drugs and Pharmaceutical Services

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under the Commission to undertake the neces-

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views through retail drug outlets. Lack of

(d) Provision of drugs and pharmaceutical ser-



but which are not being accepted.

(b) Quantitative, that is a lack of availability of drugs and pharmaceutical services to the general public and hospital patients. This deficiency can be attributed to a shortage of physical facilities and/or qualified personnel in some areas. It may also arise from the inability of the patient to pay for the drugs and services required.

E5 Improvements and Extensions of Existing Services

The need for improvements, either qualitative or quantitative, should be apparent from the preceding study.

E6 Methods of Effecting Improvements & Extensions of Services

In considering the implementation of suggested improvements and extensions of services it would be most significant to determine whether these proposals could be effected through present methods of practice, by some modification of present systems; or is such would require major changes in present patterns of practice. The Society will, in this submission and later, give consideration to ways and means of effecting such proposals and/or changes both with regard to proposals advanced by themselves and by other organizations and individuals.

E7 Pharmacy Manpower- Present Status and Anticipated Requirements

Sufficiently accurate and detailed information is not available to intelligently assess the problem here and responsibly recommend corrective measures.







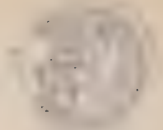
The Canadian Pharmaceutical Association has submitted an outline of a research program in this field. See Appendix "D" to the preliminary statement by the Canadian Pharmaceutical Association. This Society commends and endorses the stand of the Canadian Association. The Society considers this to be a most important research project beyond its resources, and in recommending it to the Commission, gives it assurance of full co-operation and support.

E8 The Development of a Ratio of Facilities to Population

The usual retail drug outlets found in Nova Scotia supply pharmaceutical services to the general public. They also deal in assorted "front store" items of merchandise which, in many cases, involve no professional pharmaceutical services. Many people assume, because of this that the professional talents of pharmacists are not fully utilized. Detailed study of this is necessary. The aim of such study should be to provide some significant ratio between the number of pharmacists and retail drug outlets and the number and distribution of the population of the Province.

E9 Types of Drugs, Medicines, and Therapeutic Devices Considered Essential

To give meaning to any study of the present cost of drugs there must be agreement as to the types of drugs, medicines and therapeutic devices which are considered necessary for providing adequate health services. The primary responsibility for such determination does not rest on pharmacy, but pharmacy should be consulted, and is willing to assist. Cost studies may



The Canadian Pharmaceutical Association has submitted an outline of a research program in this field. See Appendix "D" to the preliminary statement by the

committee and endorses the stand of the Canadian Association. The Society considers this to be a most important research project beyond the resources, and in recommending it to the Commission, gives its sanction of full co-operation and support.

#### The Development of a Ratio of Retailers to

The usual retail drug outlets found in Nova Scotia supply pharmaceutical services to the general public. They also deal in assorted "front store" items of merchandise which, in many cases, involve no profits.

One of the main reasons of this is that the professional values of pharmacists are not fully utilized. Detailed study of this is necessary. The aim of such study should be to provide some significant ratio between the number of pharmacists and retail drug outlets and the number and distribution of the population of the province.

#### Types of Drugs, Medicines, and Therapeutic Devices

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1 be confined to those drugs dispensed on prescription,  
2 or they may include the cost of commonly used house-  
3 hold drugs which are normally purchased without a pres-  
4 cription. The effect of this decision on the cost  
5 estimates is obvious.

6 E10 The Society, in unison with the Canadian  
7 Pharmaceutical Association, suggests that only through  
8 exhaustive cost studies can accurate estimates be es-  
9 tablished relative to suggestions or proposals which  
10 may be forthcoming as a result of the Commission's  
11 deliberations.

12 E11 The Society recommends that the Commission  
13 undertake a comprehensive study of costs relative to  
14 pharmaceutical services and provision of drugs through  
15 all existing sources as an essential research project  
16 required under term of reference (g) and as outlined in  
17 greater detail in Appendix "E" of the preliminary state-  
18 ment of the Canadian Pharmaceutical Association.

19 E12 At the preliminary hearings in Ottawa on 27th  
20 September, 1961 the Ontario Retail Pharmacists' Associ-  
21 ation suggested that the Commission "investigate the  
22 place of the drug store in the health team". The Soci-  
23 ety commends this suggestion to the Commission and  
24 urges thorough study of the fifteen points of inquiry  
25 suggested by the Ontario Retail Pharmacists' Association.  
26  
27  
28  
29  
30







APPENDIX "F"

to Submission by the  
Nova Scotia Pharmaceutical  
Society

MUNICIPAL PARTICIPATION IN HEALTH

PROGRAMS AND CARE OF INDIGENTS

F1            Three levels of government participate in the sharing of health costs in the broadest sense in the Province of Nova Scotia. The Government of Canada provides certain services itself, such as health care for armed services personnel stationed in Nova Scotia, veterans care, sick mariners care and many other services which we do not propose to deal with. It also shares in the cost of many Provincial health plans such as hospital care, capital grants for hospital construction, etc. The Government of the Province of Nova Scotia maintains many health services which will undoubtedly be dealt with in that Government's submission to this Commission. The municipal government units also carry on extensive health programs.

F2            In Nova Scotia there are 66 separate municipal units, including 3 cities, 39 towns and 24 municipalities. Each of these units has its own health program financed from its own revenues and from grants from other levels of government. The provincial Department of Municipal Affairs publishes annually an extensive report on municipal statistics which consolidates the returns from all the municipal units. In addition to this the expenditures of each unit would be available from the unit in question.

to Submission by the  
Nova Scotia Pharmaceutical  
Society

## MUNICIPAL PARTICIPATION IN HEALTH

### PROBLEMS AND CASE OF INDIAN

Three levels of government participate in the

ensuring of health costs in the broadest sense in the  
Province of Nova Scotia. The Government of Canada pro-  
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gram financed from its own revenues and from grants of

other levels of government. The provincial Department

of Municipal Affairs publishes annually an extensive

report on municipal statistics which consolidated the

returns from all the municipal units. In addition to

the expenditures of each unit would be available

from the unit in question.





F3 In the financial statements of the municipal units, and also in the departmental consolidation the following items are shown. The figures given below are from the 1959 consolidation.

F4 Public Health, Dental and Allied services cost a gross amount of \$285,857.00 for all municipal units in 1959. The estimate for 1960 is approximately \$300,000.00. This item included the following services or programs:

Medical Health Officers  
Public Health Nurses and Nursing Organizations  
Enforcement of Health Regulations  
Sanitary Inspections  
Control of Communicable Diseases  
Clinics (Mental Health clinics on an experimental basis)  
Medical Services and Drugs for Indigents  
Certificates of Insanity  
Subsidies or grants to physicians  
Victorian Order of Nurses  
St. John Ambulance Society  
Cancer Society  
Canadian Arthritis and Rheumatism Society  
Heart Foundation  
Paraplegic Association, etc.

F5 The Society has not available a breakdown of this total into these individual items. Neither has it a breakdown of the items to show what proportion, if any, of each item is concerned with drugs and pharmaceutical services.

In the financial statements of the foundation  
 units, and also in the departmental consolidation the  
 following items are shown. The figures given below  
 are from the 1957 consolidated.

cost a gross amount of \$25,000.00 for all medical  
 units in 1957. The estimate for 1960 is approximately  
 \$300,000.00. This item included the following services  
 or programs:

Medical Health Officers  
 Public Health Nurses and Nursing Organizations

Clinics (Mental Health clinics on an  
 experimental basis)

Medical Research and Training for Indians

Consultation on Psychiatry

Education of Graduate in Psychiatry

Vietnam Order of Nurses

Canadian Society

Canadian Anesthesia and Respiration Society

The society has not available a breakdown of

a breakdown of the items to show what proportion of  
 any, of each item is concerned with drugs and other  
 medical services.



F6 Under the general heading of Hospital Care the gross cost to municipal units in 1959 - the last year before the Hospital Insurance Plan became effective - was shown under the following headings:

General Hospitalization \$226,387.00

(this has now been reduced by the operation of the Hospital Insurance plan to practically nil)

Grants to General Hospitals and Conveyance of Patients to General Hospitals  
\$45,850.00

Deficits of Municipally and Privately Owned Hospitals  
\$237,461.00

These figures are not broken down so as to enable the Society to extract from them the amounts attributable to drugs and pharmaceutical services.

F7 Hospitals for the mentally ill cost the municipal units a gross amount of \$1,452,125.00 for 1959. This figure probably increased considerably in 1960, and is continuing to increase in 1961. Under the heading is included:

Municipal payments to the Provincial Hospitals

Municipally operated institutions, and payments to such institutions

Payments to Boarding and Lodging Homes

Conveyance of patients to mental hospitals.

Again it is not possible for the Society to isolate the costs of drugs and pharmaceutical services.

F8 The Society recommends that the Commission undertake a research program to determine the cost of drugs and pharmaceutical services included in the above noted programs in Nova Scotia. The Society will render all assistance that it can give within the limit of its resources.



To

Under the general heading of Hospital Care

year before the Hospital Insurance Plan became effective

tive - was shown under the following headings:

(this has now been removed by the  
operation of the Hospital Insurance  
Plan to practically all)

Transfers to General Hospitals and Conveyance of  
Patients to General Hospitals  
\$47,850.00

Deficits of Municipally and Privately

\$27,451.00

These figures are not broken down so as to enable the

Society to extract from them the amounts attributable

to drugs and pharmaceutical services.

Hospitals for the mentally ill cost the

municipal units a gross amount of \$1,422,125.00 for

1959. This figure probably increased considerably in

1960, and is continuing to increase in 1961. Under

the heading is included:

Municipal payments to the Provincial Hospital

Municipally operated institutions, and

payments to such institutions

Payments to Boarding and Lodging Homes

Conveyance of patients to mental hospitals.

Again it is not possible for the Society to isolate

the costs of drugs and pharmaceutical services.

The Society recognizes that the Commission

undertake a research program to determine the cost of

drugs and pharmaceutical services included in the above

needed program in Nova Scotia. The Society will need

all assistance that it can give within the limits of



APPENDIX "G"

to Submission by the  
Nova Scotia Pharmaceutical  
Society

THE HALIFAX VISITING DISPENSARY

G1 ~~History~~ The Halifax Visiting Dispensary was incorpor-  
ated by Chapter 110, of the Acts of Nova Scotia, 1872.  
This Act incorporated the members of the association  
for the medical treatment of the sick poor in the City  
of Halifax. It continued the then valid constitution  
and by-laws of the association.

G2 Article 11 of the constitution states that  
"The object of this Society shall be to provide and  
furnish Medical and Surgical aid, and Medicine to such  
persons as may be in need thereof and unable, by reason  
of poverty, to procure the same." The constitution is  
contained in the report of the Halifax Visiting Dispen-  
sary which is submitted as Exhibit "F".

G3 The summarized report for 1959 indicates the  
extent of services rendered.

Prescriptions dispensed for Dalhousie Clinic Patients.	5585
---	------

Prescriptions dispensed for Dispensary Patients	437
--	-----

Prescriptions dispensed for Patients of outside M.D.'s	3445
Total -	<u>9467</u>

Included in the above were 68 for  
Dartmouth and 1239 for County patients

Total attendance for surgical supplies	114
--	-----

Total patients for receiving supplies	31
---------------------------------------	----

Total visits made by the Dispensary doctors	587
--	-----

Cont'd.







1	Total patients visited during	679
2	Total families included in the above (66 were new registrations)	209
3	<del>appears to be the same as above</del>	
4	Total patients referred to Victoria General Hospital	19
5	Total Patients referred to Children's Hospital	18
6	<del>A.S.P.S.</del>	
7	Total patients referred to Nova Scotia Hospital	1
8	G4 The financial statement indicates the sources	
9	of revenue and expenditures.	
10	INCOME-	
11	From Halifax-Dartmouth United Appeal Fund	4,625.00
12	From Investments	4,039.75
13	City Grant	1,200.00
14	County Grant	800.00
15	Dartmouth Grant	200.00
16	From Sir William Young Estate	1,025.00
17	Special Gift	300.00
18	Refunds - Fees	2,876.36
19	Glasses	538.00
20	Dalhousie Student Health	800.00
21	Ref. on N.S.P.S. Fee	28.00
22		\$16,432.73
23	EXPENDITURES -	
24	Salaries	7,917.92
25	Drugs	10,851.86
26	Surgical Supplies	452.00
27	Refractions	736.00
28	Commission and Postage	159.19
29	Office Supplies	63.66
30	Telephone	59.41

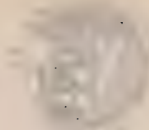
(Cont'd.)





1	Advertising and Printing	219.67
2	Insurance	20.00
3	Express Freight and Cartage	19.30
4	Laundry	7.50
5	Audit	50.00
6	N.S.P.S.	190.00
7	Interest on Advanced Funds	<u>111.59</u>
8		\$20,858.20
9	Expended	20,858.20
10	Received	<u>16,432.73</u>
11	Debit	\$ 4,425.47
12	Debit from 1958	<u>\$ 4,718.76</u>
13		\$ 9,144.23
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Continued on page 12

Insurance

Life Insurance

Policy No.

W.C.P. Co.

Policy No.

\$2,500.00

\$1,000.00

Received

\$4,500.00

Profit

\$1,000.00

Debit from 1956

\$1,000.00



APPENDIX "H"

to Submission of  
Nova Scotia Pharmaceutical  
Society

STATEMENT OF POLICY RELATIVE TO

HEALTH CARE PLANS

H1 ~~Whereas~~ The Canadian Pharmaceutical Association, in  
general meeting assembled at Hamilton, this year, adopted  
a Statement of Policy Relative to Health Care Plans.  
This Statement has been endorsed by the Society and the  
Society urges the Commission to give effect to this  
Statement of Policy when considering pharmacy matters.

H2 ~~It is recommended~~ The Society feels that health care programs  
should be examined in a light consistent with a sound  
philosophy which will assure a good standard of such  
care to every Canadian, yet which will also safeguard  
the rights of the individual and all minority segments  
of the population.

H3 ~~There are~~ There are segments of the population for  
which adequate health care represents a financial hardship.  
It is recognized that there is a certain basic  
and understandable resistance in some quarters to the  
assumption of costs relative to illness, particularly in  
relation to drugs and therapeutic procedures. The  
Society believes that neither of these is consistent  
with modern concepts of community social responsibility,  
nor with the availability of professional knowledge  
and ability.

H4 ~~Whereas~~ The cost of modern health services has risen  
to a point where many Nova Scotian families may be  
financially unable to meet the cost of a major or pro-







1 longed illness if left to their own resources. This  
2 has been recognized by the government of the province  
3 in introducing a form of universal hospital insurance  
4 against a background of basic democratic principles.  
5 But the remaining elements of health care may still  
6 present a financial problem to a portion of the popu-  
7 lation of Nova Scotia.

8 H5 The Society recognizes these existing deficien-  
9 cies and believes that governments can properly provide  
10 legislative action to relieve this situation. Such  
11 legislation should assure the practical availability  
12 of comprehensive health care, including pharmaceutical  
13 benefits to every Nova Scotian. We should look first  
14 to meeting this challenge by the expansion and exten-  
15 sion of existing voluntary medical insurance and pre-  
16 payment plans. Such plans should be expanded to pro-  
17 vide pharmaceutical services and extended so as to in-  
18 clude all who are presently ineligible to participate  
19 or who are financially unable to pay the costs involved.  
20 Subsidization of the plans from public funds would  
21 make this possible.

22 H6 Should research and study prove conclusively  
23 that it is not practical to provide an adequate standard  
24 of comprehensive health care in this manner, the  
25 Society is prepared to accept in principle and co-oper-  
26 ate in the establishment and operation of an alternative  
27 government sponsored comprehensive plan which would be  
28 consistent with all recognized precepts of good health  
29 care and which would make such care readily available  
30 to all people of Nova Scotia.





H7 To be comprehensive a health care plan must include pharmaceutical services provided by pharmacists. Pharmaceutical benefits should be in the form of pre-scribed drug services and specified therapeutic devices and NOT in the form of reimbursement.

H8 The Society dislikes compulsion but realizes that the attainment of universal coverage is most desirable in the financing of any such health care program. Compulsion disregards the rights of a minority. The degree and nature of compulsion must not be such as to emasculate the initiative of the professions, resulting in a lowering of the standards of health care, an impairment of professional education, a stifling of research and a demoralization of individual practitioners. Consequently, voluntary measure should be encouraged.

H9 The introduction of such a health care program should not stifle nor detract from efforts to provide the highest quality of health care in keeping with traditional professional responsibilities. Nothing, economic or otherwise, in such a universal scheme should be incompatible with such high standards or interfere with the priceless relationship which presently exists between patient, physician, pharmacists and other members of the health professions.

H10 The Society states that to be acceptable to the pharmacists of Nova Scotia, any comprehensive health care plan must observe the following fundamental principles in respect of pharmaceutical benefits:



27

The comprehensive health care plan must

include pharmaceutical services provided by pharmacists

and other health care professionals and specialized therapeutic services

and must be the basis of health care.

28

The health care plan must be comprehensive

and must include universal coverage for all persons

and must include the financing of any such health care plan

and must include the financing of any such health care plan

and must include the financing of any such health care plan

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29

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and must include the financing of any such health care plan

30

The health care plan must be comprehensive

and must include universal coverage for all persons

and must include the financing of any such health care plan

and must include the financing of any such health care plan



- (a) there must be recognition of the existing division of legislative responsibility concerning Pharmacy and/or drugs, and nothing shall contravene this;
- (b) drugs and all pharmaceutical services shall be supplied directly to the public only by pharmacists through legally authorized and regulated outlets. In hospitals, the supplying of drugs and related professional services shall be limited to bona fide hospital patients;
- (c) Pharmacy shall have direct representation on any body charged with the initiation and development of policies pertaining to pharmaceutical services. Pharmacists should be directly involved in administering such policies;
- (d) the patient shall be free to obtain pharmaceutical services from the pharmacist of his choice;
- (e) a pharmacist shall be free to conduct his practice, or any part thereof, outside such health care plan if he so chooses;
- (f) benefits shall include any and all drugs considered necessary by the physician for the welfare of the patient, as well as specified therapeutic devices. The only restrictions on prescribing







1 should be in terms of quantity for any  
2 single prescription and the number of  
3 times it may be repeated;

4 (g) While the Society does not look with favor  
5 on the use of deterrents, it has been  
6 necessary to introduce deterrents of a  
7 financial or otherwise restrictive nature,  
8 on pharmaceutical benefits in every major  
9 health care plan of which the Society is  
10 aware. Such deterrents should be used  
11 solely for the purpose of controlling  
12 over-utilization and NOT primarily as a  
13 source of revenue; and

14 (h) members of Pharmacy shall have the right  
15 to determine the basis of their remuner-  
16 ation for professional services as  
17 distinct from payment for materials  
18 involved in rendering pharmaceutical  
19 services. The amount and manner of such  
20 remuneration shall be a matter of  
21 negotiation from time to time to reflect  
22 changes in economic conditions.





APPENDIX I

to Submission of  
Nova Scotia Pharmaceutical  
Society

DRUG NOMENCLATURE

- THE "BRAND NAME" versus "GENERIC NAME"

CONTROVERSY

I1 The Society presents the following in the  
hope that it will assist the Commission in studying  
this problem and in making recommendations to solve it.  
The material contained in this Appendix is gained from  
the experience of the Society and from consulting the  
following sources; (a) the preliminary submission of  
the Society to the Restrictive Trade Practices Commis-  
sion, (b) the transcript of the hearings before the  
Restrictive Trade Practices Commission held in Halifax  
earlier this year; (c) material contained in the Jour-  
nal of the American Medical Association; and (d) the  
Interim Report on a Study of Pharmacy in Saskatchewan  
by the Saskatchewan Pharmaceutical Association, dated  
4 August, 1961.

I2 The material collected for submission to the  
Restrictive Trade Practices Commission relating to the  
manufacturing, distribution and selling of drugs by  
the Director of Investigation and Research, Combines  
Investigation Act, dated 1961, will be referred to as  
the "Green Book".

I3 On page 20 of the Green Book the following is  
found.

42. There are three types of names used for  
particular drugs. First, there is the chemical name







which is descriptive of the chemical composition of the drug. Second, there is the generic name which can best be defined as the common name of the drug. (Regulations under the Food and Drugs Act use the term "proper name" instead of generic name, but with the same meaning). A generic name becomes settled when the drug is listed in one of the official reference books on drugs. The reference books named in the Food and Drugs Act are:

Pharmacopea Internationalis

The British Pharmacopoeia

Pharmacopoeia of the United States

Codex Francais

The Canadian Formulary

The British Pharmaceutical Codex

The National Formulary

The label of a drug product usually indicates the standard to which a drug conforms. Thus, "B.P." or "U.S.P." after the name of a drug means that the drug conforms to the specifications for that particular drug as laid down in the British Pharmacopoeia or the Pharmacopoeia of the United States respectively. In Canada, if a standard is prescribed under the Food and Drug regulations, this Standard will govern...Third, a particular supplier will sell the drug under a registered trade name.

On page 22 of the Green Book:

44. Trade names are particularly important in the case of drugs which, because of patent control, are controlled by one or a few firms. If the pro-



which is descriptive of the chemical composition  
of the drug. Second, there is the generic name  
which can best be defined as the common name of the  
drug. (Registrations under the Food and Drugs Act  
use the term "proper name" instead of generic  
name, but with the same meaning). A generic name  
becomes settled when the drug is listed in one of  
the official reference books on drugs. The refer-  
ence books named in the Food and Drugs Act are:  
Pharmacopoeia Internationalis  
Pharmacopoeia of the United States  
Codex Pharmacopoeia  
The Canadian Pharmacopoeia  
The British Pharmacopoeia  
The National Formulary  
The label of a drug product usually indicates  
the standard to which a drug conforms. Thus, "B.P."  
or "U.S.P." after the name of a drug means that the  
drug conforms to the specifications for that par-  
ticular drug as laid down in the British Pharmacopoeia  
or in the Pharmacopoeia of the United States  
respectively. In Canada, if a standard is present  
under the Food and Drug Regulations, this stan-  
dard will govern. Third, a particular supplier  
will sell the drug under a registered trade name.  
On page 11 of the Green Book  
4. Trade names are particularly important in  
the case of drugs which, because of patent control  
are controlled by one or a few firms. It is impor-





1 motion of the drug under its trade name is success-  
2 ful, the brand name becomes the accepted name for  
3 the drug. Aureomycin appears to be almost as  
4 familiar, even to the genral public, as penecillin,  
5 yet very few people probably know the name  
6 chloretracycline.

7 I5 In ordinary usage in the drug field, no  
8 distinction is normally made between a brand name and  
9 a trade name and the special names given drug products  
10 are usually spoken of as brand names, although tech-  
11 nically they are trade names.

12 I6 There may well be a tendency to make the use  
13 of a brand name that sold criteria for judging the  
14 quality of a drug product. Obviously, the use of a  
15 brand name, by itself, is no guarantee of quality. It  
16 is the care which is used by the manufacturer which is  
17 important.

18 I7 Dr. Morrell made this point in correcting an  
19 erroneous report alleging that he considered brand  
20 name products superior. The report from the Toronto  
21 Globe and Mail, 18 Aug. 1960, reproduced in part on  
22 p. 13 of the Green Book, reads as follows:

23 "When it comes to buying top-quality drugs,  
24 the things to check are the ability, facilities,  
25 personnel and conscience of the drug manufacturer,"  
26 Dr. C.A. Morrell, Canada's chief drug inspector,  
27 said today.

28 "Neither a brand name nor a drug's generic  
29 name is the sole reliable guide to quality, he  
30 said.

and, the brand name becomes the accepted name for the drug. Ascorbyl appears to be almost as familiar, even to the general public, as penicillin. Yet very few people probably know the name chlorbutyrate.

In ordinary usage in the drug field, no distinction is normally made between a brand name and a trade name and the special names given drug products are usually spoken of as brand names, although technically they are trade names. There may well be a tendency to make the use

of a brand name what said criteria for judging the quality of a drug product. Obviously, the use of a brand name, by itself, is no guarantee of quality. In fact the name which is used for the manufacturer, which is

Dr. Morrell made this point in connecting an erroneous report alleging that he considered brand name product superior. The report from the Toronto Globe and Mail, 18 Aug. 1960, reproduced in part as follows:

"When it comes to buying top-quality drugs, the things to check are the ability, facilities, personnel and competence of the drug manufacturer. Dr. C.A. Morrell, Canada's chief drug inspector, said today: 'Neither a brand name nor a drug's general name is the sole reliable guide to quality, he



"The real point is who makes the drug and how it's made - the control system that insures careful and scientific testing for potency and stability."

I8 In the broadest sense, the names for drugs fall into categories which are set forth in the following paragraphs. There is a very useful article on this by Dr. Lloyd C. Miller of New York City in the Journal of American Medical Association of July 8, 1961 at page 27 and following, reference to this article is urged by the Society. Much of the following material is taken from that article.

I9 When first synthesized, or when first identified if derived from a natural source a potentially useful compound receives a "systematic chemical name". To be adequate and fully specific, this name must reveal every part of the compound's molecule, including any and all forms of isomerism if present, and must be such that it can describe only the compound concerned and no other. The systematic chemical name is generally so formidable that even chemists have little patience with it and tend to coin "trivial" names to abbreviate the names for specific compounds or groupings. There are numerous examples of "trivial" names. Chemically, phenol is hydroxybenzene or hydroxycyclohexatriene; yet how many recognize at once that the "trivial" name and the two systematic names are synonymous.

II0 Pharmacologists often identify new compounds during their study in the laboratory by "code numbers".



The real point is who makes the rules and how it's made - the control system that governs the rules and scientific testing for potency and safety.

10

In the present case, the rules for drugs tell two categories which are set forth in the following paragraphs. There is a very useful article on this by Dr. Lloyd G. Wilson of New York City in the Journal of American Medical Association of July 3, 1961 at page 24 and following, reference to that article is made by the Society. Much of the following material is taken from that article.

11

When drugs are synthesized, or when they are obtained from a natural source a potential chemical compound receives a "systematic chemical name". To be adequate and fully specific, this name must reflect every part of the compound's molecule, including any and all form of isomerism if present, and must be such that it can describe only the compound concerned and no other. The systematic chemical name is given exactly as formulae that even chemists have to write down with it and must be given "trivial" names to abbreviate the names for specific compounds or groups. Chemically, there are hydrocarbons or hydroxyaromatics, yet few would recognize as such that the "trivial" name and the two systematic names are closely

12

Relationships of often identical new compounds during their study in the laboratory by "trivial" names.



which are usually preceded by a common prefix distinctive of the laboratory in which the work is being done. An example is the laboratory code number MER/29, which became so well known it was adopted as a registered trademark for the anticholesteroleremic drug concerned (triparanol). If used, a compound's code number stays with it through the laboratory study and frequently through the clinical investigation.

III When tests show that a compound has real utility for therapeutic purposes, and the investigation justifies offering it for sale, a "proprietary name", is needed. Known also as a trademark, this name identifies the specific brand of the compound with the firm that owns the mark. As a rule, this is the firm that has born the expense of synthesizing the compound, and of carrying out the laboratory and clinical tests, to say nothing of bearing the cost of producing it in sufficient quantities for wide distribution, and making its virtues known to physicians. This proprietary name is therefore the exclusive, and oft times very valuable, property of the firm with which it is identified.

II2 At this stage there also appears the "generic" or "nonproprietary name". The use of the term "generic" which comes from the Latin "genus", and suggests classification into genera as is the practice in botany and zoology, is a misnomer in the drug field. The generic name does not relate to a class or genus of drugs; it denotes a single drug. Generic here is taken as opposed to specific. Specific applies to the trade







name (also called brand or proprietary name) which is specific to one sole owner, while the generic name is non-proprietary. The term non-proprietary is more accurate and descriptive, but generic is more convenient and easier to use.

See Stecker, P.G.: Generic Names of Drugs,  
Journal of Chemical Education 34:454-456  
Sept. 1957.

Il3 The term generic now has an economic connotation. A new and appropriate usage of it has sprung up to designate collectively the several brands of a given drug that are marketed by several firms; that is, the various brands of a single drug may be regarded as a family or genus of products, and their respective non-proprietary names are "generic" as a group. But it is submitted that the term "non-proprietary" deserves recognition, because its accuracy outweighs its unwieldiness.

Il4 The final class of names consists of the "official titles" used in the official reference books referred to previously. Usually, these are the non-proprietary names that have been used during the period of establishing the drug's place in rational therapy.

Il5 Much could be achieved by the co-operation of all concerned. Many desirable results would probably flow from the adoption by the Food and Drug Administration of a policy requiring, as a matter of safety, that the labelling of all new drugs subject to new drug applications should employ the name used in the official





reference books, if there is one, or find out what "common or usual name" has been established and require that it be used.

Il6 Non-proprietary names are needed as a common bond of identity in the market place. Another, and from the manufacturer's viewpoint, a more cogent reason is that non-proprietary names serve to protect trademarks.

Il7 The convenience of all will be served by making non-proprietary names as short and pronounceable as possible. Yet it is equally true that the name should point up such relationships as exist among compounds that fall into a common pharmacological group. This makes brevity difficult to achieve. It leads directly to names which have been criticized for their length. It is obvious that a choice must be made between meaningless short names and longer names that convey useful information.

Il8 The situation is immeasurably complicated in respect of the names of the radicals which form appendages to most drug names. This is dealt with at length in Dr. Miller's article.

Il9 Finally, there is another complication, for a non-proprietary name constitutes only part of the name of the dosage form of the drug, the full title of which must be used in accurate prescribing. While standard abbreviations are not provided in the United States, the situation is somewhat better in Great Britain where such are given in the British Pharmacopoeia. This applies in Canada.



reference to the fact that there is one, or more, and what  
'common or usual name' has been established and regarding  
that it is used.

Non-proprietary names are needed as a common  
bond or identity in the market place. Another, and  
from the manufacturer's viewpoint, a more cogent reason  
is that non-proprietary names serve to protect trade-

The convenience of all will be served by  
making non-proprietary names as short and pronounced  
as possible. Yet it is equally true that the name  
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Britain where such are given in the British Pharmacopoeia.  
This applies in Canada.



I20 It is not surprising, for these reasons alone, that physicians prefer to use shorter brand names.

I21 National and international groups have been trying to devise a uniform international system of nomenclature for drugs. The efforts of the World Health Organization deserve special mention. The Commission is respectfully urged to study these efforts and relate the results to the Canadian problem.

I22 Charles O. Wilson, Dean of the School of Pharmacy, Oregon State College, has studied this problem of drug nomenclature exhaustively. He states that the basic difficulty is inconsistency, attributable to poor choices of names and to lack of authority (1) to require the selection and use of a non-proprietary name for every drug entity, and (2) to prohibit the selection and use of more than one name for any single compound. One of the most serious obstacles to an orderly process of selecting non-proprietary names is the lack of uniformity in the manner in which individual pharmaceutical firms go about naming their products.

It is hoped that the pharmaceutical manufacturing industry will have valuable information to present and suggestions to make to the Commission along these lines.

I23 Two procedural changes are suggested by Dr. Miller, which he feels would go far to answering some of the complaints. The first would call for reaching an agreement within the pharmaceutical industry to use a system of code prefixes in identifying compounds dur-







ing the period of laboratory and clinical trial. The second would call for similar industry agreement to select non-proprietary names in a co-operation with some effective central authority for all new drugs before their introduction on the market, preferably at the time when new drug applications are filed with the Food and Drug Administration.

I24 It is realized that because of foreign influence in our pharmaceutical industry there are great complications to be overcome in this regard to Canada.

I25 It is also suggested that medical and pharmaceutical editors should lend the weight of their influence to the use of accepted non-proprietary nomenclature in approving articles for publication.

I26 The "brand name" vs "generic name" controversy received an airing at the Halifax hearings of the Restrictive Trade Practices Commission relating to the manufacture, distribution and sale of drugs.

I27 The Society made a preliminary submission to that Commission at that time. A copy of the submission is presented as Exhibit "G".

I28 In that submission the Society stated at page 1:

"The pharmacist is charged with the responsibility of translating the Doctor's order into effective, usable medication."

I29 Again on page 2:

"The importance of proper and adequate quality control in the manufacture of drugs cannot be over-emphasized. Pharmacists are vitally interested in





1 this. Naturally they look to reliable manufacturers  
2 who exercise reliable quality control for their  
3 pharmaceutical supplies."

4 I30 And at page 3:

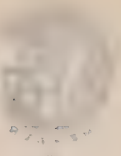
5 "A lively controversy exists concerning the  
6 relative merits of physicians prescribing by brand  
7 name or by generic name. The pharmacist finds him-  
8 self in the uncomfortable position of being squarely  
9 in the middle of this battle, although through no  
10 choice of his own. He is required by law to dis-  
11 pense prescriptions exactly as the doctor orders.  
12 He has a choice in the matter only when the doctor  
13 prescribes the medicine by its generic name. In  
14 such a case, the pharmacist may dispense either a  
15 brand name drug, or a cheaper generic drug.

16 "It is fair to say that at the present time  
17 pharmacists are reluctant to use some of the generic  
18 drugs prepared by little known or unknown manufac-  
19 turers. They are not prepared to take unwarranted  
20 chances when the health of the public is concerned."

21 I31 Continuing on page 4:

22 "Why does the physician generally use the brand  
23 name when prescribing for a patient rather than the  
24 generic name? There are probably many reasons,  
25 but just as a patient must have confidence in his  
26 physician so must the physician have confidence in  
27 the drug. The physician therefore generally tends  
28 to prescribe a preparation manufactured by a com-  
29 pany well known to him, and one that he trusts be-  
30 cause of its reputation and his experience with its  
products."





1911

the exercise of his right of property for the

"It is a very common error to suppose that

relative merits of physicians prescribing by name

name or by generic name. The pharmacist finds his

self in the uncomfortable position of being obliged

to the middle of his battle, although through no

choice of his own. He is required by law to dis

pose prescriptions exactly as the doctor orders.

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Continued on page 4:

101

"Why does the physician generally use the brand

name when prescribing for a patient rather than the

generic name? As a patient must have confidence in his

physician, so must the physician have confidence in

the drug. The physician therefore generally tends

to prescribe a preparation manufactured by a com

pany well known to him, and one that he trusts.

One of the reasons for this is the experience which he



I32 Mr. MacLeod: Dr. Charles Henry Reardon was called as a witness by the Restrictive Trade Practices Commission. Dr. Reardon is a general practitioner with some 15 or 16 years of experience in the Halifax area. The following appears on page 375 of the record of the hearings commencing at line 22.

Mr. MacLeod: Do you ever prescribe drugs by their generic names?

Dr. Reardon: No, I use the trade names.

Mr. MacLeod: What is your reason for doing that, Doctor?

Dr. Reardon: You can remember the trade names far easier than you can remember the generic names and from my point of view I cannot see what possible difference it makes.

Mr. MacLeod: I suggest to you in some cases it might make a difference in price.

Dr. Reardon: I suggest to you that in most cases it does not.

Mr. MacLeod: It is your impression that brand names and generic named drugs retail for the same price or about the same price?

Dr. Reardon: I would say in the City of Halifax that they do.

Mr. MacLeod: So that...

Dr. Reardon: For example if I was ordering cholormycetin which has a generic name of chloramphenicol, I would feel obliged to put down the name of the manufacturer whom I knew was distributing quality drugs, if that is what you are trying to get at.



Dr. Charles Henry Pearson was called as a

132

Witness by the Restrictive Trade Practices Commission.

Dr. Pearson is a general practitioner with some 15 or

16 years of experience in the Halifax area. The fol-

lowing appears on page 575 of the record of the hear-

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1 Mr. MacLeod: I take it even if you did use a generic  
2 name you would specify the brand name by  
3 a particular manufacturer?

4 Dr. Reardon: I would feel obliged to, because you are  
5 now getting to the point of the quality of  
6 drugs and why we prescribe trade names in-  
7 stead of generic names.

8 Mr. MacLeod: Yes, I am getting your reaction as a doctor  
9 in general practice?

10 Dr. Reardon: I would say that primarily I prescribe trade  
11 names because they are easier to remember  
12 and it is the way that you are used to do-  
13 ing it and you get into a habit of doing  
14 it.

15 Mr. MacLeod: That is your practice?

16 Dr. Reardon: If I prescribe by the generic name I would  
17 feel obliged to add to that one of the com-  
18 panies who supplied that drug who I felt  
19 supplied quality drugs.

20 I don't think all the drugs coming into  
21 Canada are quality drugs and I feel that we  
22 have an obligation to our patients to see  
23 to the best of our ability that what they  
24 get is the best. The prime consideration  
25 in drugs, to my point of view, is to see  
26 that the drug will do the job that you want  
27 it to do. Price is not the prime consider-  
28 ation. The prime consideration is getting  
29 the patient better. After that the price  
30 must come into it, but the prime consider-

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I don't think all the drugs coming into Canada are quality drugs and I feel that we have an obligation to our patients to get the best of our ability that what they get is the best. The prime consideration in drugs, to my point of view, is to see that the drug will do the job that you want it to do. I think it is the prime consideration. The prime consideration is to get the patient better. After that the price must come into it, but the prime consideration



1                   ation is to see that the patient gets the  
2                   drug that will cure ~~that~~ patient for that  
3                   particular disease.

4   The Chairman: I just want to get quite clear what you are  
5                   saying. If you use a generic name of a  
6                   particular drug Company, in effect you are  
7                   using the trade name of that Company?

8   Dr. Reardon: Certainly. I notice in this brief here  
9                   that all the way through it is the sugges-  
10                  tion that the small manufacturers or the  
11                  small importers of drugs, who supply drugs  
12                  that are cheaper in price than the well-  
13                  known manufacturers, do not receive the  
14                  acceptance by the doctors mainly because  
15                  the doctors have not been told that these  
16                  drugs are of the same quality as the other  
17                  ones. I think that is an important point.  
18                  All the drugs are not examined by the  
19                  food and drug group in Ottawas as for qua-  
20                  lity, biological and chemical quality or  
21                  quantitative properties. There is no good  
22                  using a drug because it is cheap if you are  
23                  going to get hills and valleys in its po-  
24                  tency in the action that it will have. If  
25                  you are going to get hills and valleys,  
26                  you do not know why your patient is not  
27                  responding to that drug, and it is like  
28                  anything else.

29                  Over the years you get to recognize that  
30                  a Company, whrther is is A,B, or C, has





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Over the years you get to recognize what  
a company, whether it is A.B. or C. has



1 put out drugs that certainly as far as you  
2 know, and you have never heard of it being  
3 otherwise, that have in their capsules or  
4 in their tablets or the kind of medicine  
5 involved, what that Company say is there.  
6 It is like having a Rolls-Royce. You don't  
7 worry about the quality because over the  
8 years you come to recognize that it is  
9 there and you come to realize that drugs  
10 supplied by certain Companies, the content  
11 in their capsules, the quality and quantity  
12 of medicine that you are prescribing are  
13 there. But you cannot be sure about a new  
14 pill for distribution and there is no real  
15 worry about them except making money. You  
16 say perhaps there is no real worry behind  
17 the larger Companies except to make money.  
18 The larger Companies spend considerable  
19 amounts of money on research in drugs. A  
20 lot of these small outfits spend nothing  
21 on research. They may only have an office  
22 in their hat, and yet they distribute drugs  
23 they bring in from Italy or France and  
24 wonder why the general public don't accept  
25 them.  
26 I think it would be very dangerous for doc-  
27 tors to accept some of these drugs that  
28 come in without having some standard of  
29 quality. If the Government at Ottawa  
30 through their group are responsible for







quality can say to the doctors, "We are examining every batch of such and such a Company's drugs and we find that it contains the ingredients and amount it is supposed to contain," you won't ever find lack of acceptance of the lower priced drugs that you mentioned.

Mr. MacLeod: When speaking of generic names and the lower cost of drugs, I take it you were speaking largely of imports?

Dr. Reardon: That is right. That pretty well includes all the so-called high cost drugs, doesn't it? They are all imported.

Mr. MacLeod: Well then, in your own practice have you had any experience at all with generic name drugs?

Dr. Reardon: Certainly, whether you use them by trade, or generic your experience is the same.

Mr. MacLeod: What I was trying to get at, did you have any experience in prescribing a drug simply by the generic name without attaching any brand to it?

Dr. Reardon: No, I don't do that.

Mr. MacLeod: You don't do that. That wouldn't have arisen in your experience?

Dr. Reardon: No. It hasn't arisen in my experience. I don't prescribe generics. I want to know what the patient is getting. I want to be sure what he is getting.



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what the patient is getting. I want to

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Dr. James William Reid, a specialist in in-



1 ternal medicine, practicing in Halifax, also gave evi-  
2 dence.

3 I34 At p. 391 of the record, Dr. Reid states:

4 Mr. MacLeod: Do you keep in touch with the costs of par-  
5 ticular drugs, what they are going to cost  
6 your patient when you prescribe a particu-  
7 lar drug?

8 Dr. Reid: No, I don't dare do that because if I knew  
9 what the cost of the drug was, I might not  
10 prescribe it. So that, generally speaking  
11 I don't look very closely at the cost of  
12 drugs.....I would not dare allow the cost  
13 of drugs to interfere with my prescribing.  
14 That would be unsound.

15 I35 Again on p. 392 at line 10:

16 Dr. Reid: If I think the patient requires a drug, I  
17 order it, regardless of cost, and mostly  
18 that does not work too much hardship....

19 I36 And on the same page at line 22:

20 Mr. MacLeod: In your practice do you ever prescribe drugs  
21 under their generic names?

22 Dr. Reid: Well, yes I do. I do when I am prescribing.  
23 I still attempt to prescribe pharmacopoeidic  
24 drugs that have been in use a long time and  
25 are standard preparations which are not ex-  
26 pensive. Where I think they are adequate.  
27 I will use those drugs prescribing from a  
28 generic name. I would do that with some of  
29 the newer drugs too, but perhaps not too  
30 frequently actually. I would mostly pres-  
cribe from the brand names, I think.



terminal medicine, practicing in Illinois, also have evi-  
dence.

134

At p. 251 of the record, Dr. Reid states:

Mr. MacLeod: Do you keep in touch with the costs of these  
thinner drugs, what they are going to cost  
your patient when you prescribe a particular  
drug?

What the cost of the drug was, I might not  
prescribe it. So that, generally speaking  
I don't look very closely at the cost of  
drugs.... I would not dare allow the cost  
of drugs to interfere with my prescribing.  
That would be unusual.

135

Again on p. 252 at line 10:

Dr. Reid: Do I think the patient requires a drug, I  
order it, regardless of cost, and insist  
that does not work too much hardship....

136

and on the same page at line 25:

In your practice do you ever prescribe drugs  
under their generic names?

Dr. Reid:

Well, yes I do. I do when I am prescribing  
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I37 And at p. 397 at line 25:

Dr. Reid: "...We can, of course, eventually if we find a new drug might work better with something else we can make our own dosage form and have the druggist make it up, which we do. "We would generally specify that drug by its generic name and add what we wish to it, and the druggist would then make it up accordingly."

Mr. Whiteley: Dr. Reid, in prescribing by generic names have you found any difference in the quality of the product which is used to fill the prescription?

Dr. Reid: No, I haven't. To assess any difference in quality would be a rather long process, and mostly we work with the dispensing chemists as a partner, as it were, in the treatment of the sick. We expect him to use only good quality drugs in our prescriptions, and, I think, by and large that is true. I think you can depend on that pretty thoroughly. I don't think any dispensing chemist would willingly, knowingly put an inferior drug in a prescription of mine, and if he did put an inferior drug into it, it would be because he did not have access or methods of confirming the quality of the drug.

In other words, that would have to go further back in its manufacture and inspection

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1 by checking, you see. Most of our druggists  
2 are completely qualified and ethical people  
3 who are using only the best quality chemi-  
4 cal they can.

5 I38 Dr. Clyde S. Marshall, a medical practitioner  
6 holding a senior position in the Department of Public  
7 Health of the Province of Nova Scotia gave evidence.  
8 He is, in his official capacity, largely concerned  
9 with the Government program for the treatment of the  
10 mentally ill.

11 I39 At page 450 of the record at line 20:

12 Mr. MacLeod: Do you have any experience, Doctor, in pur-  
13 chasing tranquilizing drugs under generic  
14 names and under brand names?

15 Dr. Marshall: Yes, we had quite an experience on that.

16 I40 On pages 451 to 457 Dr. Marshall outlined  
17 this experience in some detail. His Department ordered  
18 by generic name and saved considerable money by doing  
19 so, without, in his opinion reducing the quality of  
20 the drug. It must be noted, however, that the order  
21 under the generic name was placed only after he had  
22 thoroughly satisfied himself by extensive inquiry that  
23 the drug ordered met the standards required. It is  
24 also significant that this experience took place with  
25 one of the "older" tranquilizer drugs, and not with a  
26 new pharmaceutical product.

27 I41 The Interim Report on a Study of Pharmacy  
28 in Saskatchewan by the Saskatchewan Pharmaceutical  
29 Association, dated the 4th day of August, 1961 deals  
30 with generic prescribing on page 8, as follows:





"Generic Prescribing has been repeatedly advocated as a means of reducing prescription costs. Many such recommendations have been made on a complete misunderstanding of the significance of prescribing by generic name. When a physician prescribes a drug by a generic name, he authorizes the pharmacist to exercise his professional judgment in the selection of the manufacturer of the prescribed drug. The pharmacist assumes complete responsibility for the quality of the medication that is dispensed. It does not imply that the pharmacist is morally or legally bound to fill the prescription with the cheapest medication available. It does mean that the pharmacist might be able to reduce his inventory by carrying only one reliable brand of a given drug and might be able to reduce costs by bulk purchase of that item. It is most unlikely that a pharmacist in a community with a single physician now stocks duplicate brands of the same drug.

In a recent prescription drug survey it was reported that only 39% of the prescriptions surveyed were available from more than one manufacturer. Thus, approximately 60% of all prescriptions have no exact generic equivalent available today. While the majority of pharmacists would welcome a more rational system of drug nomenclature and generic prescribing, it is submitted that its effect on reducing the price of prescriptions would be limited.



"Generic Trending has been repeatedly

advocated as a means of reducing prescription costs. Many such recommendations have been made on a complete misunderstanding of the significance of prescribing by generic name. When a physician prescribes a drug by a generic name, he authorizes the pharmacist to exercise his professional judgment in the selection of the manufacturer of the prescribed drug. The pharmacist assumes complete responsibility for the quality of the medication that is dispensed. It does not imply that the pharmacist is morally or legally bound to fill the prescription with the cheapest medication available. It does mean that the pharmacist might be able to reduce his inventory by carrying only one reliable brand of a given drug and might be able to reduce costs by bulk purchase of that item. It is more unlikely that a pharmacist in a community with a single physician now stocks duplicate brands of the same drug.

In a recent prescription drug survey, it was reported that only 39% of the prescriptions surveyed were available from more than one manufacturer. Thus, approximately 61% of all prescriptions have no exact generic equivalent available today. While the majority of pharmacists would welcome a more rational system of drug nomenclature and generic prescribing, it is admitted that its effect on lowering the price of prescriptions would be



I42 That Report also deals with the Formulary System at p. 9, as follows:

The Formulary System has been proposed as a prescription cost reducing procedure. The effect of such a system would depend on the aim of the formulary. If the intention were to restrict all prescribing to the drugs listed in the formulary, costs may well be reduced. But the use of a formulary in such a restrictive sense would have to be worked out with the complete agreement of the medical profession. As a guide to generic prescribing, the formulary may well have an educational role.

The early and continued consultation with physicians in the economics of prescribing would appear to be a fruitful approach to reducing drug costs. Great care would have to be taken in the presentation of such a program to ensure that price was not given greater priority than therapeutic effectiveness.

#### I43 SUMMARY

The pharmacist finds himself in a peculiar and unavoidable position, not of his own making, in this controversy between "brand name" and "generic name" prescribing. The general public - and especially its vocal, though sometimes uninformed self-appointed spokesmen - reluctant to pay drug costs, seizes on an apparently simple and easily comprehended solution to the problem of cost - let all prescription be by "generic name". We have seen something of the difficulties involved in this deceptively simple appearing

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the problem of cost - let all prescription be by  
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culties involved in this deceptively simple appearing





1 solution. The Commission's study will undoubtedly  
2 reveal more.

3 I44 There are, generally speaking, three groups  
4 concerned in the supplying of drugs to the public.  
5 First, the manufacturer, second the prescribing doctor,  
6 and third the dispensing pharmacist. The pharmacist  
7 has no control over the other two. The manufacturer  
8 largely determines the cost. The physician orders the  
9 drug to be prescribed. The pharmacist must supply  
10 "what the Doctor orders" in the literal sense. Thus  
11 the choice of prescribing by brand or generic name is  
12 with the physician. If the physician prescribes by  
13 brand name the pharmacist must dispense the requested  
14 brand. Only if the physician prescribes generically  
15 can the pharmacist dispense one of several "brands"  
16 of the generic drug prescribed.

17 I45 Confidence in drugs is largely a matter of  
18 believing in the quality and quantity controls main-  
19 tained by the manufacturer.

20 I46 It may be that a wider use of "generic" by  
21 physicians will effect certain cost savings. But under  
22 no circumstances should such savings be made at the  
23 expense of quality.

24 I47 The Society respectfully recommends that  
25 the Commission make a thorough study of this problem  
26 to determine if it is feasible to simplify the present  
27 system of drug nomenclature and prescribing procedures  
28 and thus effect cost savings.  
29  
30



concerned in the supplying of drugs to the public.  
First, the manufacturer, second the prescribing doctor,  
and third the dispensing pharmacist. The pharmacist  
has no control over the other two. The manufacturer  
largely determines the cost. The physician orders the  
drug to be prescribed. The pharmacist must supply  
"what the Doctor orders" in the literal sense. Thus  
the choice of prescribing by brand or generic name is  
with the physician. If the physician prescribes by  
brand name the pharmacist must dispense the requested  
brand. Only if the physician prescribes generically  
can the pharmacist dispense one of several "brands"  
of the generic drug prescribed.

145 confidence in drugs is largely a matter of  
belonging in the quality and quantity controls main-  
tained by the manufacturer.

146 It may be that a wider use of "generics" by  
physicians will effect certain cost savings. But under  
no circumstances should such savings be made at the  
expense of quality.

147 The Society respectfully recommends that  
the Commission make a thorough study of this problem  
to determine if it is feasible to simplify the present  
system of drug nomenclature and prescribing procedures  
and thus effect cost savings.

# ROYAL COMMISSION ON HEALTH SERVICES

## HEARINGS

HELD AT

HALIFAX

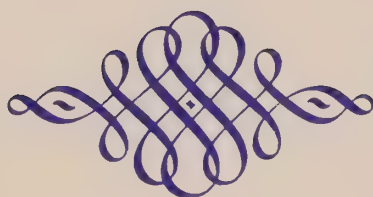
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VOLUME NUMBER:

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Evidence

Brief

Nova Scotia Federation of Labour

Brief

Evidence

Halifax-Portsmouth and District Labour

132

Canadian Nurses' Association of Nova Scotia  
Scott Division

Opening

Brief

Evidence

Registered Nurses' Association of Nova Scotia

Brief

Evidence

Canadian Foundation for Polio-myelitis and  
Rehabilitation

Opening & Summary

Brief



VOLUME 5

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing held  
at Halifax, Wednesday, November  
1st, 1961

COMMISSION MEMBERS:

Chief Justice EMMETT H. HALL -- Chairman

Miss ALICE GIRARD, R.N.

Mr. DAVID M. BALTZAN

Prof. O.J. FIRESTONE

Mr. M. WALLACE McCUTCHEON, Q.C.

Dr. C.L. STRACHAN

Dr. ARTHUR F. VAN WART

COMMISSION COUNSEL:

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MEDICAL CONSULTANT:

Dr. PIERRE JOBIN

DIRECTOR OF RESEARCH:

Prof. BERNARD BLISHEN

SECRETARY:

Maj. N. LAFRANCE

REPORT ON HEALTH SERVICES

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Mr. M. WALLACE MONTGOMERY

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Dr. RICHARD T. VAN WAT

COMMISSION COUNSEL:

Mr. R. N. HALL, Q.C.

MEDICAL CONSULTANT:

Dr. PETER JOHN

DIRECTOR OF RESEARCH:

Prof. EDWARD BISHOP

SECRETARY:

Ms J. N. LARANCE



Halifax, Nova Scotia,  
Wednesday, November 1st, 1961

--- On resuming at 9.30 a.m.

THE CHAIRMAN: The hearing will proceed with  
a submission from the Nova Scotia Association for Retarded  
Children.

SUBMISSION OF THE NOVA SCOTIA ASSOCIATION  
FOR RETARDED CHILDREN

Appearances: G. MacKenzie  
Dr. D.R.S. Howell  
H.L. Allen  
Dr. W.A. Cochrane

MR. HOWELL: Your lordship, ladies and gentlemen, let me say first how appreciative we are of the opportunity of presenting this submission to the Royal Commission as part of its investigation into the health needs of Canada. It is not certain whether you decided to commence your hearings in Nova Scotia because of our special needs or in recognition of the valuable contribution which our Province will indeed make towards such a problem as this affecting the Dominion as a whole. In any case, we welcome you to our Province and trust on future visits you will allow yourselves more time to enjoy the hospitality and amenities of this region.

It is apparent from the events which have gone on in this room during the past two days that this Commission has undertaken a tremendous task and that owing to your liberal interpretation of the Terms of Reference you will be receiving numerous submissions from many bodies and organizations directly or indirectly concerned with the health of the nation. However, we do not hesitate to bring





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THE CHAIRMAN: The hearing will proceed with a submission from the Nova Scotia Association for Retarded

SUBMISSION OF THE NOVA SCOTIA ASSOCIATION FOR RETARDED CHILDREN

Dr. D.R.S. Howell  
Dr. W.A. Cochrane

MR. HOWELL: Your lordship, ladies and gentlemen, let me say first how appreciative we are of the opportunity of presenting this submission to the Royal Commission as part of its investigation into the health needs of Nova Scotia because of our special needs or in recognition of the valuable contribution which our Province will indeed make towards such a problem as this affecting the Dominion as a whole. In any case, we welcome you to our Province and trust on future visits you will allow yourselves more time to enjoy the hospitality and amenities of this region.

It is apparent from one event which have gone on in this room during the past two days that this Commission is concerned with the health of the nation. However, we do not hesitate to bring you will be receiving numerous submissions from many bodies and organizations directly or indirectly concerned with the health of the nation.



1 to your attention the needs of a segment of the community  
2 hitherto largely neglected as compared with other handi-  
3 capped persons, and we wish to show that this group is  
4 the direct concern of a large percentage of the population.

5 In the brief from the Nova Scotia Association  
6 for Retarded Children which you have before you it is  
7 stated that it would appear that 3% of the population of  
8 Canada are mentally retarded. However, if to that large  
9 number you add the parents of the retarded children and  
10 the other members of their families it is reasonable to  
11 estimate that at least 10% of the population are directly  
12 concerned with this problem. Despite this personal involve-  
13 ment of more than one-and-three-quarter million people in  
14 Canada, public awareness and acceptance of the condition  
15 are lagging far behind that of any other disability, and  
16 the services available for retarded children and adults,  
17 whether supported by public money or private funds, are  
18 considered to be below the acceptable minimum in this  
19 Province, as is the case across the Dominion.

20 It is realized that Governments at all levels  
21 will not normally expend public monies for health or wel-  
22 fare projects unless they are convinced of public support  
23 in so doing. However, it is only fair to say that in  
24 Nova Scotia, as elsewhere in Canada, the retarded have  
25 benefited from legislation enacted by enlightened Govern-  
26 ment at all levels. However, it is considered that the  
27 services which have so far been provided are most inade-  
28 quate, and in the words of Dr. Nicholson, before you  
29 yesterday, "are just scratching the surface of the  
30 problem", and not scratching very deeply, I may say.



to your attention the needs of a segment of the community  
hitherto largely neglected as compared with other hand-

icapped persons, and we wish to show that this group is  
the direct concern of a large percentage of the population  
in the brief from the Nova Scotia Association

for Retarded Children which you have before you it is  
stated that it would appear that 1% of the population of  
Canada are mentally retarded. However, if we take large  
number you add the parents of the retarded children and  
the other members of their families it is reasonable to  
estimate that at least 10% of the population are directly  
concerned with this problem. Despite this personal involve-  
ment of more than one-and-a-half million people in  
Canada, public awareness and acceptance of the condition  
are lagging far behind that of any other disability, and  
the services available for retarded children and adults,  
whether supported by public money or private funds, are  
considered to be below the acceptable minimum in this

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services which have so far been provided are most inade-  
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yesterday, 'are just scratching the surface of the  
problem', and not approaching very close to it.





1 It is the purpose of this submission and all  
2 others which you will be receiving, to indicate ways in  
3 which necessary improvements may be effected. This is  
4 the first of ten such briefs which will be presented to  
5 you from the various Provincial associations, in addition  
6 to one from the Canadian Association, of which we are a  
7 division.

8 You will observe that we are an association  
9 of parents of the retarded and include in our membership  
10 some professional people who are working in the interests  
11 of the retarded. We have had no direct legal or literary  
12 assistance in preparing our brief to you, and we trust  
13 you will be tolerant of its deficiencies.

14 At this stage of relative public ignorance  
15 of the nature of retardation it has been thought necessary  
16 to emphasize the essential differences which exist between  
17 mental illness and mental retardation. Happily, complete  
18 relief and cure of a large percentage of cases of mental  
19 illness can in these days be achieved, whereas retardation  
20 is the impaired development of the mind which, once esta-  
21 blished, cannot in our present state of knowledge, be  
22 repaired. Unfortunately, in the minds of many this is  
23 interpreted as meaning that nothing can be done for the  
24 retarded, and this has led to a social and political  
25 inertia which in many respects is much more pronounced in  
26 the New World than in the old. In Canada and in this  
27 Province the tendency of parents to conceal those mentally  
28 handicapped members of their families from their neighbours  
29 has until very recently been encouraged by the lack of  
30 many of the appropriate diagnostic, educational,



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retardation and cure of a large percentage of cases of mental  
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handicapped members of their families from their neighbors  
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many of the appropriate diagnostic, educational,





1 recreational or vocational facilities which would enable  
2 them to develop to their full potential.

3                   Good institutional care has been provided  
4 at the Nova Scotia Training School for a number of years,  
5 but this has not catered to more than 180 educable and  
6 trainable children, and facilities for the care of the  
7 most severely retarded housed in the county homes and  
8 Halifax Mental Hospital have been seriously deficient and  
9 still are. In fact, the plight of this small segment,  
10 accounting for 1% of the mentally retarded, is a cause of  
11 great concern to our Association, and this and other facets  
12 of the care of the retarded are the justification for our  
13 submissions to you and should, we consider, be regarded as  
14 matters of the highest priority.

15                   To underline this urgency, sir, it should  
16 be pointed out that approximately 115 mentally retarded  
17 babies have been born in Canada since this Commission  
18 commenced its hearings two days ago.

19                   You will have noted that our submission to  
20 this Commission supplements the brief presented to the  
21 Government of Nova Scotia last March and makes reference  
22 to this early brief from time to time. Since a number of  
23 the measures outlined in our brief have not hitherto been  
24 provided, our Association has had difficulty in deciding  
25 which should be the responsibility of the Federal Govern-  
26 ment and which of other levels of Government, and in  
27 drawing your attention now to individual recommendations  
28 contained in our submission, it is proposed to indicate  
29 in which ways the Federal Government could be of assistance  
30 in implementing them.



recreational or vocational facilities which would enable  
 them to develop to their full potential.  
 Good institutional care has been provided  
 at the Nova Scotia Training School for a number of years,  
 but this has not catered to more than 180 students and  
 trainable children, and facilities for the care of the  
 most severely retarded housed in the county homes and  
 Halifax Mental Hospital have been seriously deficient and  
 still are. In fact, the plight of this small segment,  
 accounting for 1% of the mentally retarded, is a cause of  
 great concern to our Association, and this and other facets  
 of the care of the retarded are the justification for our  
 submissions to you and should, we consider, be regarded as  
 matters of the highest priority.  
 To underline this urgency, it should  
 be pointed out that approximately 11% mentally retarded  
 babies have been born in Canada since this Commission  
 commenced its hearings two days ago.  
 You will have noted that our submission to  
 this Commission supplements the brief presented to the  
 Government of Nova Scotia last March and makes reference  
 to this early brief from time to time. Since a number of  
 the measures outlined in our brief have not hitherto been  
 provided, our Association has had difficulty in deciding  
 which should be the responsibility of the Federal Govern-  
 ment and which of other levels of Government, and in  
 drawing your attention now to individual recommendations  
 contained in our submission, it is proposed to indicate  
 in which ways the Federal Government could be of assistance



1                   Turning to the new brief, which is the  
2 larger of the two documents that you have received, the  
3 section on diagnosis and counselling services, paragraph  
4 23 on page 6, you will realize that when parents are  
5 first faced with this problem of a retarded child in  
6 their family, their first inclination usually is to  
7 reject the diagnosis, to go elsewhere in the hope that it  
8 will be reversed. This has often created a tragic situa-  
9 tion in which families have wasted their time, their  
10 money, and those of their children in going to remote  
11 sections of North America in an effort to have the situation  
12 changed. These circumstances can only be altered by the  
13 provision of adequate diagnostic services of a calibre  
14 which create a reputation and establishes the diagnosis  
15 beyond reasonable doubt. Once parents have accepted the  
16 diagnosis and have passed through the stage of self-recrim-  
17 ination -- "Why did this happen to us?" -- they are then  
18 eager to do all they can for their retarded child. Thus  
19 they are in continuing need of expert counsel, counsel  
20 which is required in most cases through the life of the  
21 child, counsel as to the care in the home, as to the  
22 available and appropriate educational facilities, recrea-  
23 tional opportunities, vocational training, job opportuni-  
24 ties, and the like. Some of these facilities have been  
25 available through the mental health clinics provided  
26 throughout this Province, and through its local equivalent,  
27 The Child Guidance Clinic, and as far as the diagnostic  
28 services are concerned, these clinics have taken care  
29 reasonably adequately of the problem of the retarded.

30                   As far as the vital continuing counsel is



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As far as the vital continuing counsel is





1 concerned, however, because of the limitations of trained  
2 personnel within those clinics, the services have left a  
3 great deal to be desired. You will see that we have  
4 recommended greatly increased facilities for these diagno-  
5 stic and counselling clinics and the setting up of new  
6 ones.

7                   In other parts of Canada, sir, diagnostic  
8 clinics, dealing with the retarded only, are in existence  
9 and it is likely -- indeed, one may say certain -- that in  
10 a few years time such will be the need in this Province.

11                   It would seem to us that the Federal Govern-  
12 ment may contribute towards these of our needs firstly by  
13 maintaining and increasing the mental health grants and  
14 thus facilitating the training of psychiatrists, psycholo-  
15 gists and social workers and the like, the lack of which  
16 at the moment is interfering with the welfare of our  
17 children.

18                   The section on medical treatment, paragraph  
19 25 on the same page, I will deal with in association with  
20 that on research which follows later in the brief.

21                   The section on education, paragraph 26, page  
22 7, credit is due to the educational authorities of this  
23 Province at various levels for setting up certain classes,  
24 firstly for the educable retarded children. These are  
25 accepted into the regular school system and to some extent  
26 recently for classes for the trainable child. The latter  
27 are part of the regular school system in some centres and  
28 not in others. Invariably the latter classes are started  
29 by the parents of the children concerned, originally  
30 financed by them, teachers' salaries paid, the equipment



concerned, however, because of the limitations of trained personnel within those clinics, the services have left a great deal to be desired. You will see that we have

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In other parts of Canada, also, diagnostic clinics, dealing with the retarded only, are in existence and it is likely -- indeed, one may say certain -- that in a few years time such will be the need in this Province.

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1 necessary is supported by the funds from the parents, and  
2 while it is realized that education is likely to remain  
3 under the Provincial jurisdiction, as we have pointed out  
4 in our brief, we feel there is need for some survey of the  
5 educational needs of the retarded, and an assessment of  
6 those educational facilities that already exist.

7                   It would seem to us appropriate that the  
8 Federal Government might well undertake or provide finan-  
9 cial support for such a survey.

10                   The next section on institutions, paragraph  
11 29 at the top of page 8: I made reference a few moments  
12 ago to the serious deficiencies which exist in the services  
13 available for the severely retarded children and adults  
14 who are housed in the county hospitals or their equivalents  
15 -- the county homes. These deficiencies are gross and,  
16 as already indicated, are of concern to all of us and  
17 particularly to the parents concerned.

18                   Our recommendations to overcome this diffi-  
19 culty include the setting up of cottage-type regional  
20 hospitals solely for the retarded, distributed at various  
21 geographical locations throughout the Province.

22                   It is further recommended that additional  
23 attention be paid to the provision of foster home care for  
24 a number of these seriously retarded.

25                   It is suggested that the Federal Government  
26 may be of assistance in these measures in providing  
27 increased financial support for construction of such new  
28 institutions and in providing additional facilities for  
29 the training of the staff, professional and non-professio-  
30 nal.





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hospitals solely for the retarded, distributed at various

geographical locations throughout the Province.

Attention be paid to the provision of foster home care for

a number of these seriously retarded.

It is suggested that the Federal Government

should establish a special commission of inquiry to

investigate and to provide additional facilities for

the training of the staff, professional and non-professional



1 The short section on vocational classes,  
2 paragraph 35, at the bottom of page 8, I will be dealing  
3 in part with this subject as it overlaps with the section  
4 on sheltered workshops and job opportunities, but finan-  
5 cial support from the Federal Government in the proposed  
6 vocational training program is essential for its implemen-  
7 tation.

8 The sheltered workshops, paragraph 36, these  
9 are facilities in which those young adult retarded who  
10 have finished school and are not able to live independently  
11 may work at their own pace at tasks suited to their parti-  
12 cular abilities. These not only provide the dignity of  
13 labour and the sense of accomplishment to those who attend  
14 them, and, of course, are a blessing to the parents of the  
15 young adults concerned, ~~but~~ they are one means of saving  
16 the public money, and if the individuals concerned did not  
17 have these opportunities they would, in most cases, become  
18 public charges. The development which has occurred in the  
19 ability and increased morale of the youngsters concerned  
20 is remarkable and has been seen to a limited extent in  
21 this area, limited because of the relatively small facili-  
22 ties available for the retarded in this regard in Nova  
23 Scotia. Sheltered workshops are an established principle  
24 elsewhere in North America, but generally, as in the  
25 provision of job opportunities, we in Canada lag away  
26 behind all other countries, particularly those in continen-  
27 tal Europe. It is suggested in Nova Scotia, and perhaps  
28 in this Dartmouth area in particular, the sheltered work-  
29 shop might form part of a community day centre. This  
30 would be a building which might include a diagnostic and

The short section on vocational classes.

Paragraph 25, at the bottom of page 8, I will be dealing in part with this subject as it overlaps with the section on sheltered workshops and job opportunities, but I think that support from the Federal Government in the proposed vocational training program is essential for its implementation.

are facilities in which these young adult retarded children have finished school and are not safe to the independent may work at their own pace at tasks suited to their capabilities and abilities. These not only provide the dignity of labour and the sense of accomplishment to those who attend them, and, of course, are a blessing to the parents of the young adults concerned, but they are one means of saving the public money, and if the individuals concerned did not have these opportunities they would, in most cases, become public charges. The development which has occurred in the ability and increased morale of the youngsters concerned is remarkable and has been seen to a limited extent in this area, limited because of the relatively small facilities available for the retarded in this regard in Nova Scotia. Sheltered workshops are an established institution elsewhere in North America, but generally, as in the provision of job opportunities, we in Canada lag way behind all other countries, particularly those in common with Europe. It is suggested in Nova Scotia, and perhaps in this Parliament area in particular, the sheltered workshop might form part of a community day centre. There would be a building which might house a domestic and





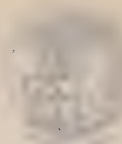
1 counselling clinic as well, would provide hospital accommo-  
2 dation for those attending the sheltered workshop from the  
3 rural areas or who were working outside the sheltered work-  
4 shop and came to the rural areas, and possibly some accommo-  
5 dation for those in need of permanent residential care.

6 The financing of such projects, the mechanism  
7 of financing is not known to us, but it would seem that  
8 this would be an appropriate place for financial support  
9 from governments, and particularly perhaps from the  
10 Federal Government.

11 Now, sir, with your permission, I wish to  
12 call on Dr. Cochrane, who will comment on the sections in  
13 medical treatment and research. Dr. Cochrane is Associate  
14 Professor of Pediatrics, Dalhousie University Medical  
15 School, and is himself conducting considerable research  
16 along these lines.

17 THE CHAIRMAN: Dr. Cochrane.

18 DR. COCHRANE: Your lordship, ladies and  
19 gentlemen, the size of the problem has been indicated to  
20 you by the figures given to you by Dr. Howell. If I  
21 could first comment with regard to medical treatment and  
22 then perhaps on research. I think it is safe to say that  
23 up to the present time there has been no actual treatment  
24 as such for a definitely mentally retarded child in the  
25 sense of some miraculous treatment as in the treatment of  
26 pneumonia with penicillin. However, we believe that with  
27 guidance and teaching they can be well-adjusted in society  
28 and do well. The medical treatment is tied into research,  
29 but is now shifting to the role of prevention rather than  
30 actual treatment of the problem we have. I am talking



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Now, sir, with your permission, I wish to  
call on Dr. Cochran, who will comment on the sections in  
medical treatment and research. Dr. Cochran is Associate  
Professor of Pediatrics, Delft State University Medical  
School, and is himself conducting considerable research

THE CHAIRMAN: Dr. Cochran.

DR. COCHRAN: Your Honorship, ladies and  
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you by the figures given to you by Dr. Howell. If I  
could first comment with regard to medical treatment and  
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and do well. The medical treatment is tied into research,  
but is now shifting to the role of prevention rather than  
treatment of the problem we have. I am talking





1 only about medical welfare. At the present time we are  
2 aware of at least six conditions, that if the child is  
3 recognized early to have one of these biochemical disorders  
4 the retardation may be improved with this particular type  
5 of therapy.

6           The tie-in with research in this point of  
7 view, I might simply for a moment demonstrate to you an  
8 illustrative case. At the present time in this Province  
9 we have a project that is determining in the urine of  
10 babies of five or six weeks of age the presence of substan-  
11 ces which we know at present will indicate if this child  
12 is not retarded now will be retarded later. These children  
13 are born normal, apparently fully normal, and over a  
14 period of weeks they progressively deteriorate. If these  
15 children are identified early enough and placed on a diet  
16 the retardation, as I mentioned, can be prevented. We  
17 place this in the simple disc of a child, the mother does  
18 this, and she sends it back to us, to our laboratory to  
19 test. It is sponsored by the Medical Society of Nova  
20 Scotia and the finances for this are through a Federal  
21 health grant. We determine six different substances in  
22 the urine of the baby. I will demonstrate this. This is  
23 simply a disc of a five or six-week old baby which is  
24 apparently normal, and we put a few drops of chemical  
25 substance on this and a very significant discolouration  
26 occurs, a bluish-greenish discolouration occurs. This  
27 means that this child will be a fairly retarded child,  
28 although at the moment he is perfectly normal.

29           Now, it has been quite well demonstrated,  
30 certainly in the United States and Great Britain, that if



...present to it



1 we could pick this child up by three months of age, place  
2 it on a restricted diet, we have a chance of preventing  
3 or at least limiting retardation, because these children  
4 end up with an I.Q. of less than 30, having started with  
5 an I.Q. of 100.

6           The question then arises as to treatment.  
7 This child can then be placed on a special diet. For this  
8 child it may run into \$2,000 per year for the first one  
9 or two years, and then the cost will lessen, although it  
10 may have to remain on this particular diet. It has been  
11 found in Great Britain that these children cost \$15,000  
12 to \$20,000 in their lifetime. This work we are doing would  
13 cost in the range of \$4,000 in terms of treatment, and  
14 this is simply to demonstrate the aspect of treatment in  
15 some types of mental retardation and relating to the  
16 problem of prevention.

17           To move into the area of research, I think  
18 it is safe to say that a great deal of research is being  
19 done to study the causes and looking for other types of  
20 chemical disorders such as this that, if recognized early,  
21 can be treated. About 65% of the causes of mental retarda-  
22 tion is due to a pre-natal factor. Perhaps about 5% of  
23 the retarded fit into the group of chemical aberrations.  
24 We don't know if this can be increased to 15% of the total;  
25 this is something we will only know after a period of time  
26 and investigation. From the point of view of research -  
27 and I think this relates to mentally retarded children,  
28 but I think it also relates to the emotionally disturbed  
29 child in many cases - one may envision first the require-  
30 ment of a basic scientific institute in which basic

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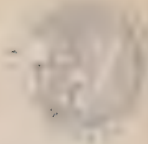




1 research is done in the line of neuro-chemistry, that is  
2 the brain cell function, how it works, what components  
3 of the body and chemicals in the body are needed for its  
4 normal function. This may well be done in a central  
5 laboratory, with research in regional laboratories in  
6 Canada. The idea would be to do a basic research, collect  
7 data and distribute it to the other research centres in  
8 Canada.

9           The second point is the question of support,  
10 financial support for research projects. I think it is  
11 fairly safe to say that very little overall is being done  
12 with regard to the research of the mentally retarded child  
13 in Canada, in contrast with the vast sums which are being  
14 spent in certainly the United States and to a great extent  
15 in Great Britain. So financial support is required for  
16 basic research, social research and for the introduction  
17 of such products across the country, as I have demonstrated  
18 here today.

19           Also we would require people for research,  
20 and we find it difficult to get money to support the people.  
21 It is not difficult sometimes to get major equipment assis-  
22 tance, but it is very difficult sometimes to get support  
23 for people, and by this I mean getting a young physician  
24 to come into this vast field of mental illness. This would  
25 require financial support for a young physician to train  
26 for one, certainly two, years at a salary of \$5,000 or  
27 \$7,000, to encourage him to do basic work in the line of  
28 mental illness and then to come back and conduct, we hope,  
29 research projects. The reason I mention sums of \$5,000,  
30 \$7,000 is that we are competing with south of the border



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1 where the standard salary for that type of thing is \$5,000  
2 or \$7,000, whereas we are usually only able to obtain  
3 \$3,400 or \$3,500. So we have to actually have the finan-  
4 cial basis if we are to keep our research workers, parti-  
5 cularly in this line.

6 In terms of again personnel, and support of  
7 personnel, I think one has to keep in mind the question of  
8 genetics, because genetics are becoming more and more impor-  
9 tant in the understanding of this disease. The use of a  
10 genetic counsellor is very important in this regard. We  
11 are aware that certainly by no means are all the causes  
12 of mental retardation inherited, but we are aware that  
13 this mother, as has been demonstrated today, has a 25%  
14 chance of producing the same child again. She and the  
15 father would need genetic counsel. In other words, we  
16 receive enquiries from many parents who lose children -  
17 "What chance have I to have the same child?" A physician  
18 who is trained in medicine as well as inheritance and  
19 genetic problems can sit down and discuss it with parents.  
20 We can test the urine, blood, perhaps even sweat and  
21 determine whether the father or the mother is a carrier  
22 of a certain disease, that, knowing the disease, we can  
23 tell them they have a 25% or 50% chance of having that  
24 type of child. I think one can envision perhaps having  
25 laboratories to carry out these tests. Today frequently  
26 we have blood testing prior to marriage, and so on, and  
27 we have information before this child was born, and perhaps  
28 this type of thing is also necessary. At least one can  
29 get some idea what to expect and knowing that it is a  
30 possibility at a very early stage and perhaps prevent it.





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are going to have a genetic counselor in the future.

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get some idea what to expect and knowing that it is a  
possibility at a very early stage and perhaps prevent it.



1 I should mention also the question of support  
2 for nurses and teachers in terms of again social research  
3 and research within a given institution. I think it is  
4 also necessary that in a given region there should be  
5 incorporated in a major hospital a given number of beds  
6 available that can be used for mentally retarded children  
7 for the purpose of investigating and studying the child  
8 admitted to this particular hospital. I am aware that  
9 this is being done in one centre in Ontario where funds  
10 are given by the Provincial Government for 20 beds which  
11 are devoted entirely to the treatment of the mentally  
12 retarded. We hope that this would be extended to other  
13 parts of the country.

14 Finally, I think this is basically all I  
15 wish to comment on, and perhaps I could leave with you  
16 the demonstration of this project which we are doing,  
17 because it is self-explanatory.

18 THE CHAIRMAN: Thank you very much, Dr.  
19 Cochrane.

20 DR. HOWELL: The section on recreational  
21 facilities in paragraph 46, page 12, is, I think, self-  
22 explanatory. We feel that this recently announced plan  
23 of the Federal Government to assist in a program to  
24 improve the physical fitness of Canadians should certainly  
25 apply specifically to the retarded.

26 The section which is headed "Justice in the  
27 Courts", paragraph 47, page 13, perhaps you would prefer  
28 to ask some questions or make some comments on this, sir,  
29 and I will not elaborate on it at the moment.

30 On the same page, "Job Placement", page 13,

I should mention also the question of transport

and research within a given institution. I think it is also necessary that in a given region there should be incorporated in a major hospital a given number of beds available that can be used for mentally retarded children for the purpose of investigating and studying the child admitted to this particular hospital. I am aware that this is being done in one centre in Ontario where funds are given by the Provincial Government for 20 beds which are devoted entirely to the treatment of the mentally retarded. We hope that this would be extended to other parts of the country.

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On the same page, "Job Placement", page 13,





1 covers, we feel, a most important aspect in the provision  
2 of proper facilities for the retarded. As I have indicated,  
3 Canada lags behind in providing training and employment  
4 opportunities for the retarded adult. Once these youngsters  
5 graduate from the classes most of them become public  
6 charges and, indeed, potential delinquents, and yet we  
7 know that 80% of the mentally retarded are capable of being  
8 partially or totally self-supporting. The establishment  
9 of the job placement officer in this area is resulting in  
10 the satisfactory employment of the surprisingly large  
11 number of local moderately retarded adults. This is a  
12 service which could not be obtained through the local  
13 rehabilitation facilities provided by the Federal Govern-  
14 ment or the Provincial Government, and we feel that the  
15 employees, for example, of the National Employment Service  
16 do not appear at present to be able to devote sufficient  
17 time to this need. We recommend, therefore, that the  
18 Federal Government, recognizing this fact, establish  
19 financial support for job placement officers of the type  
20 I have indicated. In other countries, and specifically  
21 in the United Kingdom, certain legislation exists requiring  
22 industrial concerns who employ more than 100 people to  
23 include in their employees a certain percentage of the  
24 handicapped. This is a matter of law. We do not believe,  
25 sir, that this legislation has been enacted purely on  
26 humanitarian grounds. The financial saving concerned has  
27 been shown to be considerable in terms of saving public  
28 money. I do not need to emphasize the advantages to the  
29 individuals concerned. We recommend that a study of this  
30 legislation be enacted, be undertaken with a view to



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 2 of proper facilities for the retarded. As I have indicated,  
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 4 opportunities for the retarded adult. Once these youngsters  
 5 graduate from the classes most of them become public  
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 7 know that 60% of the mentally retarded are capable of being  
 8 partially or totally self-sustaining. The establishment  
 9 of the job placement officer in this area is resulting in  
 10 the satisfactory employment of the surprisingly large  
 11 number of local mentally retarded adults. This is a  
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 13 rehabilitation facilities provided by the Federal Govern-  
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 23 been shown to be considerable in terms of saving money.  
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 25 individual concerned. We recommend that a study of this  
 26 legislation be enacted, be undertaken with a view to



1 introducing such legislation in this country.

2 The section on Public Acceptance and Under-  
3 standing, paragraph 54, page 14, is another way of under-  
4 standing the public need for education in all fields.

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1 In concluding my initial submission, I  
2 wish to point out that these briefs, this submission,  
3 should not be interpreted as a demand that the parents of  
4 retarded children consider that the whole responsibility  
5 should be upon the Federal Government at any level.  
6 Rather it is intended to indicate the ways in which it is  
7 considered appropriate for the Federal Government, because  
8 of its special powers and privileges, to undertake a  
9 greatly expanded program of aid and encouragement to the  
10 mentally retarded of all ages.

11 THE CHAIRMAN: Thank you, Dr. Howell.

12 COMMISSIONER FIRESTONE: Dr. Howell, I have  
13 a question. It relates to Section 12 of your brief:  
14 "Changes in the Income Tax Act". You recommend in this  
15 paragraph that the Income Tax Act be amended to provide  
16 special deductions for such things as drugs and nursing  
17 services. I am sure you are aware that such deductions  
18 are already permitted for drugs if they are medically  
19 prescribed and a receipt is provided, and the same is  
20 true for nursing services. The same may be true for  
21 other expenditures, and you mentioned special diets which  
22 at the moment is not included as an allowable income tax  
23 deduction, and I wondered if it would be possible for your  
24 Provincial organization to suggest to the parent organiza-  
25 tion when they are submitting to us a national submission  
26 to submit to us proposals of the kind of expenditures  
27 they would like included in deductions, and the kind of  
28 formula they would like used. In other words, we would  
29 like to have a specific formula when we come to deal with  
30 it in regard to making recommendations.

In concluding my initial submission, I wish to point out that these briefs, this submission, should not be interpreted as a demand that the parents of retarded children consider that the whole responsibility should be upon the Federal Government at any level. Rather it is intended to indicate the ways in which it is considered appropriate for the Federal Government, because of its special powers and privileges, to undertake a greatly expanded program of aid and encouragement to the mentally retarded of all ages.

THE CHAIRMAN: Thank you, Mr. Howell.

COMMISSIONER FINESTONE: Dr. Howell, I have

a question. It relates to Section 12 of your brief: "Changes in the Income Tax Act". You recommend in this paragraph that the Income Tax Act be amended to provide special deductions for such things as drugs and nursing services. I am sure you are aware that such deductions are already permitted for drugs if they are medically prescribed and a receipt is provided, and the same is true for nursing services. The same may be true for other expenditures, and you mentioned special diets which at the moment is not included as an allowable income tax deduction, and I wondered if it would be possible for your Provincial organization to suggest to the parent organization when they are submitting to us a national submission to us submit to us proposals of the kind of expenditures they would like included in deductions, and the kind of formulas they would like used. In other words, we would like to have specific formulas when we come to deal with it in regard to making recommendations.





1 DR. HOWELL: Thank you sir, that is a most  
2 valuable suggestion.

3 THE CHAIRMAN: Have you been able to work  
4 out any program in Nova Scotia whereby the elementary  
5 educational system accepts responsibility, either in part  
6 or in whole, for the education of these children, or of  
7 those who are capable of being educated?

8 DR. HOWELL: Yes sir, and if I may, I would  
9 like to call on Mr. George MacKenzie to answer that  
10 question. He is the Chief Inspector of Schools for this  
11 Province.

12 MR. MacKENZIE: Your lordship, in Nova  
13 Scotia the educational program is defined under what is  
14 called the Foundation Program under the Educational Act,  
15 and if a local board, municipal or county, is willing to  
16 establish such classes, then it has the optional power to  
17 include it under the Foundation Program and financial  
18 support from the Department of Education is given to all  
19 boards under terms defined by the Educational Act. So the  
20 aid by the Department of Education is similar in nature to  
21 the aid for other classes. At the present time though  
22 there is no requirement, that is local boards or school  
23 boards are not required to form such classes, but they may  
24 do so, and if they do so they are assisted as are other  
25 classes.

26 THE CHAIRMAN: In some Provinces, in parti-  
27 cular, one Province, it has been possible to have the  
28 elementary school system accept this, that it has the  
29 responsibility of educating all children, and therefore  
30 if a child was not mentally retarded it would find its way

DR. HOWARD: Thank you sir, that is a most

THE CHAIRMAN: Have you been able to work

out any program in Nova Scotia whereby the elementary  
education system assumes responsibility, either in part  
or in whole, for the education of these children, or of  
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question. He is the Chief Inspector of Schools for this  
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MR. MACKENZIE: Your Lordship, in Nova  
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called the Foundation Program under the Educational Act,  
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larly one Province, it has been possible to have the  
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if a child was not mentally retarded it would find its way





1 into the system and would cost 'X' dollars a year cost  
2 to the municipality and the Province. And then schools  
3 have been established, and most of the financing for those  
4 schools then comes from the elementary school system, and  
5 so a rural school at which there may be one or two chil-  
6 dren of this type, would go to the special school, paid  
7 for from local taxation and Government grant. I was  
8 wondering if you would care to give that idea some conside-  
9 ration and to bring forward some recommendation on it as  
10 to its expansion, or whether it is a feasible thing  
11 Province-wide. I mean, not necessarily at the moment, but  
12 I mean eventually, in the overall brief from the Canadian  
13 Association.

14 MR. MacKENZIE: Your lordship, I would just  
15 like to make the comment that we are aware of this situa-  
16 tion.

17 THE CHAIRMAN: The two schools I am talking  
18 about are the John Dolan School in Saskatoon is one, and  
19 the Harrow de Groot School in Regina is the other.

20 MR. MacKENZIE: Our Act specifies that all  
21 children should be educated, but just by tradition and  
22 custom, and because of the fact that the school system  
23 really didn't have classes set up for these children,  
24 they have been neglected and have not gone, and I would  
25 say that it is impracticable, or at least very difficult  
26 for a parent of a retarded child to insist on education  
27 for his retarded child, because that puts him and his  
28 child on the spot, but I would say in general terms in  
29 Nova Scotia the provision of education for retarded  
30 children through public funds is on the increase, and





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have been established, and most of the financing for these

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to the expansion, or whether it is a feasible thing

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I mean eventually, in the overall picture from the Canadian

MR. MACFARLANE: Your lordship, I would find

time to make the comment that we are aware of this situa-

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about are the John Deere School in Saskatoon is one, and

the Harvey de Groot School in Regina is the other.

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children should be educated, but by tradition and

custom, and because of the fact that the school system

hasn't really didn't have classes set up for these children,

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for a parent of a retarded child to insist on education

for his retarded child, because that puts him and his

child on the spot, but I would say in general terms in

your words the question of education for retarded

children through public funds is on the increase, and



1 there is provision in our legislation that it can be done,  
2 and it is being done to some extent, although, as our  
3 brief points out, there remains very much to be done in  
4 the future, and there is just a start made.

5 THE SECRETARY: The submission will be known  
6 as Exhibit 15, and the submission that your organization  
7 made to the Government of Nova Scotia will be known as  
8 Exhibit 15A.

9  
10 --- EXHIBIT NO. 15: Submission of the Nova Scotia Asso-  
11 ciation for Retarded Children.

12 --- EXHIBIT NO. 15A: Submission of the Nova Scotia Asso-  
13 ciation for Retarded Children to the  
14 Provincial Government dated March,  
15 1961.

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3. Other points out, there remains very much to be done in

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THE SECRETARY: The submission will be known

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--- EXHIBIT NO. 15A: Submission of the Nova Scotia Land-  
station for Registered Children.

--- EXHIBIT NO. 15A: Submission of the Nova Scotia Land-  
station for Registered Children to the  
Provincial Government dated March,





INTRODUCTION

The following presentation is from the members of the Nova Scotia Association for Retarded Children, a Provincial Division of the Canadian Association for Retarded Children, whose aims and objects, as stated in the constitution, may be found in Appendix A of the Nova Scotia Association Retarded Children's Brief to the Nova Scotia Government, of March, 1961.

The Canadian Association was formed following action by groups of interested people in a number of Provinces of Canada, the majority of whom were parents of retarded children, to provide education, care, and research into the cause of their condition, for mentally retarded children.

The Nova Scotia Association was constituted in November, 1958, with two local branches. At present there are branch associations in Halifax, Dartmouth, Kings County, Pictou County, Sydney, Yarmouth, Truro, and Glace Bay. Groups of people in several other centres have shown interest in getting branches established, and an association recently formed in Antigonish will presumably be affiliated with the Provincial Association in due course.

The Association has been greatly encouraged by the assistance, frequently entirely unsolicited, accorded to it by individuals and organizations throughout the Province. It is apparent that a substantial number of people are sympathetic to the work being done.

The Association has also been encouraged by the





1 support received from departments of the Provincial  
2 Government, particularly Education, Public Health, and  
3 Public Welfare, and their respective ministers, who have  
4 already acted on a number of recommendations made by the  
5 Association.

6 Many of the problems of retarded children  
7 are properly the concern of the Provincial Government,  
8 which represents all of the people of the Province. In-  
9 deed, many of these problems have been accepted for a  
10 long time by that Government, and a great deal has been  
11 done to meet them. The Association believes, however,  
12 that this is an appropriate time to review the situation,  
13 and formulate plans which will lead to adequate solution  
14 of the problems on a long-term basis.

15 Accordingly, the Association is very  
16 pleased that the Royal Commission has agreed to most with  
17 its representatives, to discuss this brief, which contains  
18 the views of the Association regarding the problems of the  
19 retarded in this Province, and recommendations on how all  
20 interested parties may cooperate in meeting them.

21 Certain of the measures necessary to deal  
22 with the problems of the mentally retarded would appear  
23 to be the current responsibility of the Federal Govern-  
24 ment, and many of these measures also have been accepted  
25 as such by the Federal Government, and have been carried  
26 out in whole or in part. (Included in these are legis-  
27 lation and/or financial assistance in the fields of in-  
28 stitutional care, welfare benefits, Disable Persons'  
29 Allowance, etc.).

30 Some of these measures would appear to the



support received from departments of the Provincial Government, particularly, Education, Public Health, and Public Welfare, and their respective ministers, who have already acted on a number of recommendations made by the Association.

Many of the problems of retarded children are properly the concern of the Provincial Government, which represents all of the people of the Province. Indeed, many of these problems have been accepted for a long time by that Government, and a great deal has been done to meet them. The Association believes, however, that this is an appropriate time to review the situation and formulate plans which will lead to adequate solution of the problems on a long-term basis.

Accordingly, the Association is very pleased that the Royal Commission has agreed to meet with its representatives, to discuss this brief, which contains the views of the Association regarding the problems of the retarded in this Province, and recommendations of how all interested parties may cooperate in meeting them.

Certain of the measures necessary to deal with the problems of the mentally retarded would appear to be the concern of the Federal Government, and many of these measures have been accepted as such by the Federal Government, and have been carried out in whole or in part. Included in these are legislation and/or financial assistance in the fields of institutional care, welfare benefits, public housing, etc.).

Some of these measures would appear to be



1 Association to be in need of adjustment or expansion.  
2 Other facets of the care of the mentally retarded, not  
3 currently accepted as the responsibility of any of the  
4 various levels of Government, may well be considered the  
5 concern of the Federal Government.

6 It is not considered appropriate for the  
7 Association to indicate which of these matters may event-  
8 ually be considered the responsibility of the Federal  
9 Government, which of the Provincial Government, and which  
10 of the Local Governments, and it is therefore proposed  
11 to outline certain of the measures considered necessary  
12 for the present and future health needs of the retarded  
13 persons of the Dominion as a whole, and of Nova Scotia in  
14 particular.

15 DEFINITION OF MENTAL RETARDATION

16  
17 Mental retardation is impaired development  
18 of the mind due to sickness or accident. It is not  
19 mental illness. It is physical damage to the brain which  
20 cannot be repaired, although the individual potentialities  
21 of the mentally handicapped at all levels of intellect  
22 can be significantly increased by intelligent planning,  
23 favorable environment, and loving care.

24 The needs of the mentally retarded vary  
25 considerably at different levels of intellectual capacity,  
26 and for purposes of convenience it is customary to refer  
27 to the "mildly retarded." "the moderately retarded",  
28 and "the severely retarded." More exact descriptions of  
29 these varying types of retardation, together with other  
30 nomenclature commonly used by educational and welfare



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Mental retardation is impaired development  
 of the mind due to sickness or accident. It is not  
 mental illness. It is physical damage to the brain which  
 cannot be repaired, although the individual's potentialities  
 of the mind are not exhausted at all levels of intelligence.  
 can be significantly increased by intelligent planning.  
 "Mental retardation is a condition of the mind, and is not  
 a disease of the body, and is not a defect of the body."

The needs of the mentally retarded vary  
 considerably at different levels of intellectual capacity  
 and for purposes of convenience it is customary to refer  
 to the "mildly retarded," "the severely retarded,"  
 and "the profoundly retarded." These exact descriptions of  
 these groups are not of importance, together with other  
 terminology commonly used by educational and welfare





authorities, are given elsewhere in this brief.

### CAUSES

Many of the causes of mental retardation are obscure or still imperfectly understood, although research is disclosing more and more of the responsible factors. Among these are serious illnesses of the mother during pregnancy, maternal malnutrition, brain damage caused during birth injury, abnormal Rh factor, certain brain diseases such as some forms of meningitis, head injuries caused by accidents, and abnormalities of body chemistry.

Abnormalities of chromosomal structure are responsible for some cases of familial mental retardation, but it is apparent that mental retardation can strike any family, regardless of intellect, race, or social status.

### INCIDENCE

Defining mental retardation as being present in those whose intelligence quotient is below 75% it is generally agreed that in the Western World 3% of the population is mentally retarded. This means that in Canada there are more than 500,000 retarded, and in the Province of Nova Scotia more than 21,000.

It is rather difficult to be sure which of the many needs of the retarded should be classed as health needs. If "health" is restricted to mean physical health, or even mental health in the commonly accepted





1 sense that these terms refer to the proper functioning  
2 of the various organs of the body, and of the mind, then  
3 the health needs of a great many retarded persons are no  
4 different from those of normal people. This is important,  
5 as mentally retarded persons must not be classed as  
6 mentally ill. Admittedly, it is frequently more difficult  
7 for the retarded to attain the sense of well-being and  
8 feeling of satisfaction that results from the knowledge  
9 that a difficult task has been well done, and this, to-  
10 gether with a lack of understanding of their problems,  
11 by society in general, and more especially the members of  
12 their own families, often constitute a severe hazard to  
13 their mental health. However, in an environment where  
14 excessive stress is avoided, and where the retarded are  
15 accepted as worthy persons and can experience success  
16 appropriate to their abilities, there appears to be little  
17 difference between normal and retarded people in the  
18 incidence of mental illness.

19 On the other hand, the basic cause of mental  
20 retardation frequently may be identified as a specific  
21 bodily defect or malfunction. Each such defect or mal-  
22 function that is discovered, (and some have been discovered  
23 very recently indeed), gives rise to the hope that methods  
24 of ameliorating, curing, or best of all, preventing the  
25 problem, may be found by medical research. Some remark-  
26 able results have already been obtained, and promising  
27 investigations are now being carried on along several  
28 lines.

29 Nevertheless, the Association feels that  
30 all special needs which result from mental retardation



sense that these terms refer to the proper functioning of the various organs of the body, and of the mind, then the mental needs of a great many retarded persons are no different from those of normal people. This is important, as mentally retarded persons may not be classed as mentally ill. Admittedly, it is frequently more difficult for the retarded to obtain the sense of well-being and feeling of satisfaction that results from the knowledge that a difficult task has been well done, and this, together with a lack of understanding of their problems, by itself, in a normal, and more especially the members of their own families, often constitutes a severe hazard to their mental health. However, in an environment where excessive stress is avoided, and where the retarded are accepted as worthy persons and can experience success appropriate to their abilities, there appears to be little difference between normal and retarded people in the incidence of mental illness.

On the other hand, the basic cause of mental retardation frequently may be identified as a specific bodily defect or malformation. Even such defects or malfunctions may be discovered, (and some have been discovered very recently indeed), giving rise to the hope that methods of amelioration, curing, or best of all, preventing the problem, may be found by medical research. Some remarkable results have already been obtained, and promising investigations are now being carried on along several lines. Nevertheless, the association exists that



1 are properly the concern of this Commission, inasmuch as  
2 they affect the health and welfare of the individual  
3 concerned. These needs are very great and whether they  
4 should be classed as health needs, education needs, or  
5 welfare needs, is not considered nearly so important as  
6 recognizing the needs as real ones and making positive  
7 efforts to meet them.

8                   The extent to which these needs are now  
9 being met varies greatly in Nova Scotia. In one or two  
10 areas substantial progress has been made. Generally  
11 speaking, this has been accomplished through the co-  
12 operative efforts of the Nova Scotia Association for  
13 Retarded Children; the Provincial Government, (especially  
14 the departments of Education, Public Health and Public  
15 Welfare) the municipal governments, and the parents of  
16 the children, who frequently face extremely difficult  
17 conditions.

18                   As already indicated the Association made  
19 numerous recommendations to the Provincial Government in  
20 March, 1961, and the attention of the members of this  
21 Royal Commission is drawn to these recommendations, which  
22 are contained in the attached Brief. Mention will be  
23 made of specific sections of that Brief to the Nova Scotia  
24 Government from time to time during the present submission.

25                   The Association feels that the Government  
26 of Canada should assist in meeting the special needs of  
27 the retarded in three ways - (1) by extending the exist-  
28 ing Federal-Provincial financial grants to assist the  
29 Provinces in carrying out essential programs; (2) by  
30 participating directly in projects that properly come







1 under its jurisdiction, and (3) by giving leadership and  
2 direction in all areas affecting the mentally retarded  
3 population.

4           The Association is not attempting to dis-  
5 tinguish between the responsibilities of the Federal  
6 Government and the Provincial Government in this matter.  
7 Instead, it proposes to set forth the special needs of  
8 the retarded, together with some comments on the extent  
9 to which each is being met, and the measures which it  
10 recommends should be taken by government to improve  
11 present practices. It leaves the Commission to decide  
12 which level of government should be responsible, and,  
13 in those cases where the Provincial Government is con-  
14 sidered to be responsible, the extent to which assistance  
15 should be provided by the Federal Government in the form  
16 of financial grants, or other direct measures.

17 (1) Diagnosis: (Reference - Pages 18-20 of Nova Scotia  
18 Association for Retarded Children's  
19 Brief attached).

20           An adequate examination to determine the  
21 cause of apparent or suspected mental retardation should  
22 be provided for every child at an early age. This implies  
23 the provision of Diagnostic Clinics with highly trained  
24 staffs, strategically located throughout the Province.  
25 It is necessary that there be enough clinics that the  
26 children can be re-examined periodically as required,  
27 that their parents may receive guidance and counselling,  
28 and that treatment may be extended as long as necessary  
29 for those whose condition require it.

30           At the present time facilities are quite

direction in all cases affecting the mentally retarded population.

The Association is not attempting to dis-

tinguish between the responsibilities of the Federal Government and the Provincial Government in this matter.

Instead, it proposes to set forth the social needs of the retarded, together with some comments on the extent to which each is being met, and the measures which it

recommends should be taken by Government at various present practices. It leaves the question of whether which level of government should be responsible, and in those cases where the Provincial Government is or

should be provided by the Federal Government in the form of financial grants, or other direct measures.

(1) Diagnostic - (Reference - para 10-20 of Nova Scotia

Association for the Retarded Children's

Report attached)

In medical examination to determine the

cause of abnormal or suspected mental retardation should be provided for every child at an early age. This implies

the provision of Diagnostic Clinics with highly trained

It is necessary that there be enough clinics and the

outlier can be well-served periodically as required.

and that treatment may be extended as long as necessary.

At the present time facilities are quite



1 inadequate. This is not to deny the excellent work being  
2 done by some clinics, hospitals and individuals, but the  
3 fact is that the facilities now available cannot meet the  
4 need.

5 (2) Medical Treatment:

6 In practically all cases where mental re-  
7 tardation is due to a physical defect or chemical mal-  
8 function, the amount of retardation continually increases  
9 as time goes on, and in most cases, it is not possible,  
10 when treatment is delayed, for a child to make as much  
11 progress as if the treatment had started earlier. Con-  
12 sequently, it is imperative that when a child is found  
13 to have a disability which would be liable to cause re-  
14 tardation, that he receive adequate preventative treat-  
15 ment regardless of the ability of his parents to pay for  
16 it. From the humanitarian point of view no other course  
17 of action can be considered, and from the economic point  
18 of view, assuring that a child will become a productive,  
19 rather than a dependent citizen is sound business  
20 procedure.

21 (3) Special Classes for Trainable Pupils and Auxiliary  
22 Classes for Educable Pupils in the Public Schools,  
23 or in Schools Operated by Voluntary Agencies.

24 Considerable progress has been made in the  
25 provision of separate classes for mentally retarded  
26 pupils in Nova Scotia. All the classes for the educable  
27 retarded are in the public schools, while there are ap-  
28 proximately the same numbers of classes for the trainable  
29 operated by the Nova Scotia Association for Retarded  
30 Children as there are in the public schools.





independent. This is not only the excellent work which  
has been done in the past, but also the excellent work which  
is being done at present.

### (2) Medical Treatment

In practically all cases where mental re-

habilitation is due to a physical defect or chemical mal-

function, the amount of retardation continually increases

as time goes on, and in most cases, it is not possible

when treatment is delayed, for a child to make as much

progress as if the treatment had started earlier. Con-

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the same.

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of view, assuming that a child will become a productive

member of the community, it is a sound business

### (3) Special Classes for Feeble-Minded Pupils and Adults

Classes for Feeble-Minded Pupils in the Public Schools

or in Schools Operated by Voluntary Agencies

Considerable progress has been made in the

provision of separate classes for mentally retarded

pupils in New Mexico. All the classes for the feeble-

minded are in the public schools, and there are ex-

cepted by the New Mexico Association for Retarded

Children as there are in the public schools.



1                   Nevertheless, there are still many more  
2 retarded children in regular classes or not attending  
3 school at all than there are in separate classes.

4                   No reliable data is available on the  
5 number of retarded children in Nova Scotia. However, it  
6 seems likely that 3% of the population are retarded,  
7 based on surveys in other places where living conditions  
8 and the population appear to be similar to those in Nova  
9 Scotia. If this is so, it would be expected that five  
10 to six thousand pupils in Nova Scotia should be classed  
11 as retarded. It is obvious that some attempt should be  
12 made to survey the educational needs of the retarded,  
13 and we believe the Federal Government should provide the  
14 stimulus in this direction.

15 (4) Institutions for the Full Time Care of the Custodial  
16 Retarded and of the Educable and Trainable who have  
17 no Homes or Unsuitable Homes: (Reference - Pages  
18 4-7 of the Nova Scotia Association for Retarded  
19 Children's Brief)

20                   A number of mentally retarded persons, who  
21 should be classes as custodial cases, are now housed in  
22 the mental hospitals throughout the province.

23                   Some of the educable and trainable child-  
24 ren are housed at the Nova Scotia Training School, where  
25 they receive excellent care and training.

26                   Facilities to care for those now in the  
27 mental hospitals are urgently needed.

28                   Additional accommodation is required at  
29 the Nova Scotia Training School to care for those now on  
30 a waiting list.



Nevertheless, there are still many more retarded children in regular classes or not attending school at all than there are in separate classes. Available data is available on the number of retarded children in Nova Scotia. However, it seems likely that 1% of the population are retarded, based on surveys in other places where living conditions and the population appear to be similar to those in Nova Scotia. If this is so, it would be a total of about five to six thousand people in Nova Scotia who should be classified as retarded. It is obvious that some attempt should be made to survey the educational needs of the retarded.

## (c) Instructions for the Full Time Care of the Retarded

Retarded and of the Educable and Trainable who have

Part of the Nova Scotia Association for the Retarded

A number of mentally retarded persons, who should be classified as custodial cases, are now housed in the mental hospitals throughout the province.

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Additional accommodation is required at the Nova Scotia Training School to care for these now in





1                   The N.S.A.R.C. recommends that, following  
2 a survey to determine the need, additional accommodation  
3 be provided for those not presently being served with  
4 consideration for the adult retarded also.

5                   The Association further recommends that  
6 greater efforts be made to find accommodation for more  
7 of the retarded in foster homes.

8   (5) Special Vocational Classes, either in Regular or  
9       Special Vocational Schools, to provide Training for  
10      Appropriate Occupations for those able to become  
11      Independent Members of Society: (Reference - Page  
12      21 of the Nova Scotia Association for Retarded  
13      Children's Brief).

14                  There are many retarded children, who,  
15 with proper training under well trained and understand-  
16 ing teachers, can learn to master occupations which do  
17 not require much intellectual capacity. It is recom-  
18 mended that the vocational training program should make  
19 provision for these pupils, who now, because of the lack  
20 of opportunity for training are apt to become dependent  
21 members of society.

22   (6) Sheltered Workshops, where those who have finished  
23       School and are not able to Live Independently, May  
24       Work at their Own Pace at Tasks Suited to Their  
25       Varied Abilities: (Reference - Page 22 of the Nova  
26       Scotia Association for Retarded Children's Brief).

27                  One sheltered workshop has been operated  
28 in the Halifax - Dartmouth area, sponsored by the Junior  
29 League of Halifax and the March of Dimes. A small number  
30 of mentally retarded persons have been accepted at this





shop, but it has been operated primarily for physically handicapped persons. However, enough experience has been gained in this province and elsewhere to indicate that special workshops in Community Day Centres for the mentally retarded could be successfully operated. If they were established, they would undoubtedly provide an opportunity for many persons to live far more satisfying and productive lives than are possible for them at present, relieving almost intolerable home conditions at the same time.

(7) Research: (Reference - Pages 26-28 of the Nova Scotia Association for Retarded Children's Brief).

Possibly the most striking aspect of the problem of mental retardation is that so little is known about it. Studies on the incidence, causes, and methods of treatment of this condition are urgently needed. New methods of education should be explored to assist teachers working with retarded pupils.

The Association recommends that a broad program of research, both medical and educational, at the national level be sponsored by the Government of Canada, to help to solve the many problems facing those working with retarded persons.

To facilitate the carrying out of medical research programs it is essential that facilities be available for the study of certain cases of mental retardation. It would be necessary, therefore, that hospital bed facilities be available in a children's hospital for the study of mentally retarded children. In the event of an addition to any medical scientific





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(7) Reference - Pages 25-26 of the above

Scotts Association for Retarded Children's Report.

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1 institution in the Maritimes, serious consideration should  
2 be given for the incorporation of a special section to  
3 study the problem of mental retardation. Research facil-  
4 ities and personnel should be available in the institute  
5 to carry out specific projects in mentally retarded  
6 children or adults with regard to genetic and biochemical  
7 studies. In the Maritimes it would seem necessary to  
8 have at least ten beds that could be devoted exclusively  
9 to the study of the problem of mental retardation, with  
10 supporting grants available to provide for personnel  
11 and equipment continuing on a long term basis.

12           The treatment of mental retardation in  
13 most cases resolves itself into education, training,  
14 physiotherapy and social service and genetic counselling.  
15 It would, therefore, be important that in any major in-  
16 stitute a genetic counsellor, preferably a medical  
17 geneticist, be available both for a study of the parti-  
18 cular cases and also to advise and recommend to parents  
19 the chances of their reproducing a similar mentally re-  
20 tarded child.

21           At the present time there is great interest  
22 in the particular chemical disorders that may be dian-  
23 nosed at an early age, and with proper dietary treatment  
24 (restriction or addition to the diet) mental retardation  
25 may be prevented, or the severity of retardation lessened.  
26 It would seem justifiable that the government (municipal,  
27 provincial or federal) be requested to provide the funds  
28 for the special dietary treatment of certain cases of  
29 mental retardation that are related to the inability to  
30 handle substances normally present in the diet. It is







1 likely these children would have to continue on this diet  
2 for most of their lifetime, although after the second  
3 year when the rapidity of brain development has lessened,  
4 the diet would likely be less costly and less restrictive.

5           The advancement of our knowledge in the  
6 problem of neruochemistry, both in relation to the  
7 mentally retarded child and adult, as well as the  
8 mentally ill (emotional child and adult), could be  
9 handled by the formation of a government-sponsored and  
10 run central neurochemistry institute, devoted to the  
11 study of normal and abnormal brain cell function. This  
12 institute should have good liaison with all the medical  
13 schools and research departments throughout the country.  
14 It would be able to advise and assist in setting up re-  
15 search programs, as well as carry out basic scientific  
16 research in the field of neuro-chemistry.

17           One may envision the necessity of having  
18 a government sponsored laboratory in the Province of  
19 Nova Scotia which would be devoted to the testing of  
20 newly married or engaged men and women who would be  
21 planning to be married and produce offspring. By measur-  
22 ing certain substances in blood, sweat, urine or carry-  
23 ing out various test procedures, it would be possible  
24 to recognize one or both the parents as being carriers  
25 of a particular type of disease entity which would likely  
26 result in producing a mentally retarded child. This type  
27 of laboratory would be comparable to the pre-marital  
28 testing of the blood for the presence of syphilis. It  
29 is recognized that one would not be able by law to prevent  
30 the marriage of the individuals, or prevent them from

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1 having children, but with the assistance of a medical  
2 geneticist one might have some idea of their chances of  
3 producing a defective child. The previous knowledge of  
4 a possible disease entity would allow the physician or  
5 research scientist to observe and study the child  
6 shortly after birth, and in certain cases provide early  
7 treatment that would likely prevent the mental retardation.

8 It would also seem necessary that routine  
9 testing of the urine of newborn babies for certain harm-  
10 ful substances be carried out as both a public health  
11 measure, as well as a voluntary procedure done by the  
12 medical profession in their offices. An example would be  
13 the routine testing of all infants for the presence of  
14 phenylpyruvic acid in the urine, which if present would  
15 suggest the problem of phenylketonuria. If the infants  
16 were diagnosed at 3 to 5 weeks of age and placed on  
17 proper dietary therapy it is likely the retardation could  
18 be prevented or at least minimized. It is most likely  
19 that during the next few years more disorders similar to  
20 phenylketonuria will be found and therefore simple test  
21 procedures will have to be devised and incorporated and  
22 used to find potentially affected individuals in their  
23 early weeks or months of life.

24 Funds should also be available to provide  
25 special training grants for medical and non-medical  
26 scientists or nursing personnel to engage in extensive  
27 post-graduate study in the problem related to mental  
28 retardation or mental illness. These individuals would  
29 return and head up research departments devoted to the  
30 study of retarded children. This would likely involve



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retardation or mental illness. These individuals would

return and head up research department devoted to the

study of mental illness. This would be very helpful



1 sums of \$6,000 to \$7,500 a year with travel assistance  
2 for a minimal period of 2 years. The salary for train-  
3 ing of special nursing personnel would likely be lower  
4 but these well trained people should be given more scope  
5 to improve conditions in the local hospitals for the  
6 chronically ill housing many of the seriously retarded in  
7 Nova Scotia at present.

8 (8) Facilities for Appropriate Physical Exercise and  
9 Social and Recreational Activities:

10 Retarded children are seldom able to  
11 compete successfully with normal children in competitive  
12 games or activities which require physical coordination  
13 or mental alertness. The result is that they have no  
14 opportunity to participate in group activities involving  
15 physical activity. This in turn results in a lack of  
16 noncomitant advantages of group fellowship and ~~social~~  
17 contacts. A major problem is to finance the payment of  
18 instructors and assistants to carry on suitable programs  
19 for the retarded. The recently announced plan of the  
20 Federal Government to assist in a national program to  
21 improve the physical fitness of Canadians presumably is  
22 intended to include all citizens. The Association wishes  
23 to point out that unless this program specifically  
24 states that the retarded should be included, they will  
25 almost certainly continue to be neglected.

26 (9) Justice in the Courts:

27 When retarded persons are tried and  
28 sentenced for misdemeanours or crimes, they frequently  
29 are treated in a way that is essentially unjust, because  
30 the courts do not have knowledge of their disabilities,







1 with the result that they are sentenced as if they were  
2 normal mentally.

3 The Association recommends that all courts  
4 should have available as consultants, psychologists and  
5 psychiatrists, who could advise the presiding officers  
6 regarding the condition of retarded people brought before  
7 them. We would also suggest that the Criminal Code be  
8 revised to include specific safeguards to protect those  
9 who are, in most cases, not responsible for their actions.

10 The Association does not wish to condone  
11 or excuse unsocial or criminal acts by the retarded. It  
12 suggest, however, that it would frequently be better for  
13 society, and more just to the retarded, if they were to  
14 be sentenced to a training school, or placed under the  
15 control of a probation officer, rather than being sent  
16 to a jail or penitentiary where they would come under  
17 the influence of hardened criminals.

18 (1) Job Placement: (Reference - Page 23 of the Nova  
19 Scotia Association Retarded Children's Brief).

20 Retarded people generally find it more  
21 difficult to obtain employment than do normal citizens.  
22 Generally, they need longer periods than do the average  
23 to adjust to a strange environment, and they usually take  
24 longer to learn new job requirements.

25 Consequently, they need special counsell-  
26 ing and assistance to find work, and they need super-  
27 vision during the period of adjusting to new positions.  
28 A job-placement officer, engaged by the Halifax and  
29 Dartmouth branches of the N.S.A.R.C. with financial as-  
30 sistance from the Commercial Travellers Association, has





1 demonstrated that employers, if properly approached,  
2 will cooperate by hiring retarded persons and that they  
3 frequently find them to be very satisfactory employees.

4                   The Association recommends that the Federal  
5 Government should assist the retarded in a smiliar way not  
6 by trained counsellors attached to the local offices of  
7 the National Employment Service who cannot at present  
8 devote sufficient time to the need, but preferably to  
9 provide grants for local employment of such persons,  
10 deemed suitable by the supervisor of special classes  
11 in the Provincial Department of Education, or even by  
12 the Provincial Coordinator of Rehabilitation.

13                   The Association further recommends that  
14 large industrial firms should be required to hire a  
15 certain number of mentally handicapped persons, as has  
16 been done in England.

17 (II) Public Acceptance and Understanding:

18                   It is sad to relate that many Canadians  
19 are unaware of the problem of mental retardation, and  
20 this is one field where the Federal Government could and  
21 should assist in helping Volunteer Agencies, such as our  
22 own, overcome public apathy. As has been said, some 3%  
23 of our population are retarded to a greater or lesser  
24 degree, and the magnitude of the problem should be  
25 forcibly impressed on each and everyone of us. The  
26 National Film Board should be encouraged to feature a  
27 series of films on mental retardation, while the various  
28 publications of the Department of National Health and  
29 Welfare, Ottawa, should make reference, to a greater  
30 extent, of the needs of the Retarded, the progress being







1 made in Canada and Overseas, and the way in which they  
2 can be helped. Only by public acceptance can the re-  
3 tarded be integrated into Canadian Society, with result-  
4 ing improvement in their motivation and functioning.

5 (12) Changes in the Income Tax Act:

6 Of recent years, the definition of allow-  
7 able medical expenses has been broadened, and in this  
8 connection we would like to see some tangible financial  
9 relief given to the parents and/or guardians of the  
10 retarded. It is recommended that this could be ac-  
11 complished by allowing the costs of special diets, nurs-  
12 ing services, special drugs, etc., as medical deductions  
13 under the Income Tax Act.

14 The Nova Scotia Association for Retarded  
15 Children welcomes this opportunity to present its views  
16 to the Royal Commission on Health Services, and we trust  
17 that our submission will be given serious thought and  
18 consideration. As parents and friends of the retarded,  
19 we realize our own responsibilities in providing for  
20 these handicapped children and adults, but, nevertheless,  
21 the problem is of such a magnitude as to warrant the  
22 support, assistance and encouragement of all levels of  
23 government.

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PREFACE

SUMMARY OF RECOMMENDATIONS

The Nova Scotia Division of the Canadian Association for Retarded Children recommends that the Government of Canada should assist in meeting the special needs of the mentally retarded in three ways:

1) By extending the existing Federal-Provincial financial grants to assist the Provinces in carrying out essential programs;

2) By participating directly in projects which properly come under its jurisdiction and

3) By giving leadership and direction in all matters affecting the mentally retarded, which comprises 3% of the population.

Specifically it is recommended that the Canadian Government concern itself in the following services to the mentally retarded:

a) Diagnosis and Counselling

b) Medical Treatment Facilities

c) Survey of Educational Needs of Educable and Trainable Retarded

d) Additional Institutional and/or Foster Home Care of the Retarded

e) Vocational Training

f) Sheltered Workshops

g) Medical, Social and Educational Research

h) Recreational Activities

i) Legislative Measures

j) Job Placement and Employment Opportunities

k) Public Acceptance and Understanding

l) Income Tax Relief





## INTRODUCTION

The following presentation is from the members of the Nova Scotia Association for Retarded Children, a provincial organization affiliated with the Canadian Association for Retarded Children, whose aims and objects, as stated in the constitution, may be found in Appendix A.

The Canadian Association was formed following action by groups of interested people in a number of provinces of Canada, the majority of whom were parents of retarded children, to provide education, care, and research into the cause of their condition, for mentally retarded children.

The Nova Scotia Association was constituted in November, 1958, with two local branches. At present there are branch associations in Halifax, Dartmouth, Kings County, Pictou County, Sydney, Yarmouth, Truro, and Glace Bay. Groups of people in several other centres have shown interest in getting branches established, and an association recently formed in Antigonish will presumably be affiliated with the Provincial Association in due course.

The Association has been greatly encouraged by the assistance, frequently entirely unsolicited, accorded to it by individuals and organizations throughout the Province. It is apparent that a substantial number of people are sympathetic to the work being done.

The Association has also been encouraged by the support received from various departments of





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by the support received from various departments of



1 government, particularly Education, public health, and  
2 public welfare, and their respective minister, who have  
3 already acted on a number of recommendations made by the  
4 Association.

5 Many of the problems of retarded children  
6 are properly the concern of the government, which repre-  
7 sents all of the people of the Province. Indeed, many  
8 of these problems have been accepted for a long time by  
9 the Government, and a great deal has been done to meet  
10 them. The Association believes, however, that this is  
11 an appropriate time to review the situation, and formu-  
12 late plans which will lead to adequate solution of the  
13 problems on a long-term basis.

14 Accordingly, the Association is very  
15 pleased that the Government has agreed to meet with its  
16 representatives, to discuss this brief, which contains  
17 the views of the Association regarding the problems of  
18 the retarded in this Province, and recommendations on  
19 how all interested parties may cooperate in meeting them.

20  
21 DEFINITION OF MENTAL  
RETARDATION

22 Mental retardation is impaired development  
23 of the mind due to sickness or accident. It is not mental  
24 illness. It is physical damage to the brain which cannot  
25 be repaired, although the individual potentialities of  
26 the mentally handicapped at all levels of intellect can  
27 be significantly increased by intelligent planning,  
28 favorable environment, and loving care.

29 The needs of the mentally retarded vary  
30







considerably at different levels of intellectual capacity, and for purposes of convenience it is customary to refer to the "mildly retarded," "the moderately retarded," and "the severely retarded." More exact descriptions of these varying types of retardation, together with other nomenclature commonly used by educational and welfare authorities, are given elsewhere in this brief.

### CAUSES

Many of the causes of mental retardation are obscure or still imperfectly understood, although research is disclosing more and more of the responsible factors. Among these are serious illnesses of the mother during pregnancy, maternal malnutrition, brain damage caused during birth injury, abnormal Rh factor, certain brain diseases such as some forms of meningitis, head injuries caused by accidents, and abnormalities of body chemistry.

Abnormalities of chromosomal structure are responsible for some cases of familial mental retardation, but it is apparent that mental retardation can strike any family, regardless of intellect, race or social status.

### INCIDENCE

Defining mental retardation as being present in those whose intelligence quotient is below 75%, it is generally agreed that in the Western World 3% of the population is mentally retarded. This means that in Canada there are more than 500,000 retarded, and





1 in the Province of Nova Scotia more than 21,000.

2  
3 INSTITUTIONAL CARE

4 Some retarded people, for various reasons,  
5 require care in an institution established for this  
6 purpose. Included among them are the following:

- 7 1. Grossly retarded persons who cannot  
8 be taught by presently known methods  
9 to care for their personal needs or  
10 profit from an educational or training  
11 program. Their I.Q.'s are very low -  
12 generally below 30 - and many are unable  
13 to talk, walk, or control bodily functions  
14 such as excretion.

- 15 2. Trainable retarded persons of all age  
16 groups having I.Q.'s from about 30 to  
17 about 50, who  
18 a) lack satisfactory homes and care,  
19 for whom foster homes cannot be found.  
20 In some cases they have additional  
21 handicaps such as epilepsy. Some may  
22 be potential delinquents because of the  
23 environment in which they live, and  
24 may have been convicted of minor of-  
25 fenses. At present, children of this  
26 type are frequently committed to an  
27 institution for delinquents where they  
28 associate with an older group who are  
29 a bad influence on them. Most of them  
30 would be much better off at the N.S.







1 Training School for a longer period  
2 than they spend in the delinquents'  
3 home.

4 b) are of school age, but are unable  
5 for some reason to travel each day to a  
6 special school.

7 3. Educable retarded persons having I.Q.'s  
8 from about 50 to about 75 who do not have  
9 proper homes, and for whom foster homes  
10 cannot be found. In some cases they may  
11 have additional handicaps such as  
12 epilepsy, or a crippling disability.

13 4. Retarded persons who usually live at  
14 home, but require care for a period be-  
15 cause the parents or guardians become ill,  
16 or for some other reason require a  
17 respite. They are frequently a severe  
18 drain on the resources of the family,  
19 and a threat to the mental health of the  
20 parents and normal brothers and sisters  
21 who look after them.

#### 22 INCIDENCE

23 The number of retarded who require care  
24 in institutions is not known for sure. There are now  
25 105 educable and 60 trainable children at the Nova Scotia  
26 Training School, and additional facilities are being add-  
27 ed to accommodate 20 more educable girls. The Associ-  
28 ation feels that excellent work is being done at this  
29 institution and is pleased to hear that its facilities  
30







are being expanded.

A recent survey found 96 grossly mentally retarded children in municipal hospitals for the mentally ill.

Estimates based on surveys in other places indicate that the minimum number of grossly retarded persons requiring custodial care in the province is from 210 to 250. The maximum figures obtained from these estimates are considerably higher.

#### NEEDS OF THE CUSTODIAL RETARDED

The needs of this group are varied and may be summarized as follows:

1. humane care and treatment of the totally disabled in such a manner that they will be comfortable. This usually requires total care in bed.
2. Training of the more able to as high a degree of usefulness and development as their abilities permit. If they have the benefit of a good education suited to their individual abilities, many can become independent or semi-independent members of the community.
3. Care of the retarded adults who are unable to find places to live in the community. Some of them are now housed in municipal hospitals, frequently in close association with mentally ill patients, while others are in municipal homes.





RECOMMENDATIONS

The Association recommends that the following institutions be maintained or established for the care of mentally retarded persons:

1. The Nova Scotia Training School

This school, which provides care and training for trainable and educable children, is being expanded by the conversion of an existing building to a dormitory which will house 20 additional educable girls. The Association believes this school should continue to be the sole institution for this work. The best information available to the Association indicates that a major expansion of the Training School is not likely to be required. However, some expansion is urgently needed to care for the delinquent children, who are not criminals, but require care and guidance and are now usually committed to places like the Shelburne School for Boys. From forty to sixty additional beds would probably be needed. As is stated in another section of the brief, the Association believes that educable children, who are not mentally ill or seriously disturbed emotionally, should be housed in foster homes if possible. This same principle should apply to trainable retarded children who can be placed in homes near enough to special classes that they can attend every day. If this principle is accepted and a sound policy of procuring and supervising foster homes is adopted, it may not be necessary to expand the Training School beyond this amount. The Association wishes to commend the Government on its recently enacted amendments of the procedure for admission of children to the school.







2. Homes for Grossly Retarded Persons

The Association recommends that the helpless or near-helpless retarded be housed in regional institutions, probably four in number, located close to medical and psychological diagnostic centres. These institutions, which might be either large houses suitably renovated, or new buildings especially designed for the purpose, should have facilities for caring for the personal needs of the grossly retarded, who in most cases, must stay continually in bed. The most pressing need is to withdraw retarded children from the municipal hospitals. When this has been done the needs of grossly retarded adults should be assessed, and it is quite possible that the best solution of this problem is to house them in the same buildings as the grossly retarded children.

3. Homes for Retarded Adults

Although this Association was founded to help retarded children, it is concerned with the needs of all retarded persons, including adults. It recommends that retarded adults who are not independent should, if possible, be looked after in foster homes. If it not possible to obtain enough foster homes to meet the need, other arrangements should be made for their accommodation in institutions separate from the mentally ill.

Those who are grossly retarded may, as was stated above, be accommodated in the special institutions for this type of person, including children.

Less seriously retarded adults should be accommodated in municipal homes. These homes should be







1 located in pleasant surroundings in rural areas and the  
2 inmates should be encouraged to perform work suitable to  
3 their mental and physical capacities.

#### 4 FOSTER HOME CARE

5 It is an accepted fact that children have  
6 the right to live in their own homes and to have the love  
7 and security which a home provides; however, there are  
8 times when the family is not sufficiently strong or stable  
9 enough to carry unaided the burden of a mentally retarded  
10 child. The absence of one or both parents from the home,  
11 the presence of a large number of brothers and sisters,  
12 or the danger of the child becoming a juvenile delinquent  
13 are a few justifiable reasons why some children need to  
14 be cared for outside of their own homes.

15 At the present time there is only the Nova  
16 Scotia Training School to offer care for the moderately  
17 and mildly mentally retarded child, and one licensed  
18 boarding home to give care to four or six severely mental-  
19 ly retarded children. The lengthy waiting list of child-  
20 ren waiting admission to the School points out the need  
21 for an additional service for a child who cannot remain  
22 in his own home.

23 In a great many training schools for  
24 mentally retarded children in the United States and  
25 Canada are "foster family care" programs, which are ex-  
26 tensions of the institution into the community. The re-  
27 sponsibility for the children remains the same as though  
28 they were living on the grounds of the institution. The  
29 Social Service Department of the School has the  
30





1 responsibility for selecting and approving the homes.  
2 This department also selects the children for foster care.  
3 The sum of \$2.00 a day is the average rate paid for the  
4 child's care.

5           The Nova Scotia Training School, through  
6 its social service department, finds boarding homes for  
7 a few boys and girls over 18 years who are eligible for  
8 Disability Pension. Could not an extension to this  
9 service be considered for the younger children at the  
10 School who are not benefiting from training? These child-  
11 ren by using boarding homes could give opportunity to  
12 other children who can profit from the specialized train-  
13 ing. Could not the service be extended to find boarding  
14 homes for the most needy cases on the waiting list? It  
15 would be cheaper in the long run to place young children  
16 pending admission to the School in boarding homes. The  
17 cost of maintaining a child for seven or eight years at  
18 the Nova Scotia Training School is considerably more than  
19 \$14.00 a week. Then, too, the young mentally retarded  
20 child who is in danger of becoming a delinquent would  
21 not find himself in a reformatory because no plan was  
22 available for him.

23           If the foster care program could be ex-  
24 tended to cover the child who needs temporary boarding  
25 care, and to the occasional more seriously mentally re-  
26 tarder child for whom institutional care does not seem to  
27 be essential, then there will not be the need for Nova  
28 Scotia to have large institutions to care for mentally  
29 retarded children.

30           We are aware that a "foster family care"







1 program could not be operated without trained personnel.  
2 This would, no doubt, mean that an additional person, a  
3 social worker, would have to be added to the Social  
4 Service Staff at the Nova Scotia Training School.

## 5 EDUCATIONAL FACILITIES

### 6 Introduction

7 To avoid ambiguity, some of the terms used  
8 in this section are defined as follows:

9 retarded children - children of school age, who are not  
10 able to follow the regular school program because of  
11 mental retardation.

12 educable retarded children - those whose I.Q.'s are from  
13 about 50 to about 75. These children are usually able  
14 to master considerable academic work, to learn to read  
15 simple material, to do simple arithmetic, and to learn  
16 enough to be able to live independently and hold jobs as  
17 adults.

18 auxiliary classes - separate school classes for educable  
19 retarded children.

20 trainable retarded children - those whose I.Q. are from  
21 about 35 to about 50. Some of these children can learn  
22 to read very simple material, but many do not read at all  
23 and usually are unable to become independent members of  
24 the community as adults. Some of them are able to work  
25 in the environment of a sheltered workshop.

26 special classes - separate school classes for trainable  
27 retarded children.

28 This section of the brief deals only with  
29 the education of retarded children in the public schools  
30







1 of the province.

2 As was pointed out earlier in this brief,  
3 the best information available indicates that approxi-  
4 mately 3% of all children are mentally retarded to a degree  
5 that they require an educational program quite different  
6 from that needed by normal children. The number of pupils  
7 now enrolled in the public scholls of Nova Scotia is  
8 approximately 180,000. Thus it appears that considerably  
9 more than 5,000 pupils would benefit from separate classes.  
10 Generally, it is better for both the retarded and the  
11 normal groups to educate those who are retarded in separ-  
12 ate classes.

13 It is unlikely that in the foreseeable  
14 future all retarded pupils can be placed in auxiliary or  
15 special classes, as there will doubtless continue to be  
16 small schools serving areas of scattered population.  
17 Nevertheless, as one class could be found, on the average,  
18 among each 500 pupils, most of the forty-two towns and  
19 probably an equal number of municipal areas have suffici-  
20 ently large numbers of pupils to require auziliary  
21 classes. It is not known definitely how many areas have  
22 a sufficient number of trainable pupils to require a  
23 special class, but it is likely that there should be such  
24 a class in every centre of population having 5,000 people.  
25 In areas of sparse population, the children undoubtedly  
26 are present, but conveyance is frequently difficult for  
27 these pupils, so that they may be more properly educated  
28 in the Training School of the Department of Welfare.

29 It is therefore clear that the educational  
30 program for retarded children in the public schools must

As was pointed out earlier in this paper,

approximately 3% of all children are mentally retarded to a degree that they require an educational program quite different from that needed by normal children. The number of pupils now enrolled in the public schools of New York is approximately 1,800,000. Thus it appears that considerably more than 50,000 pupils would benefit from separate classes. Generally, it is better for both the retarded and the normal groups to educate those who are retarded in separate classes.

It is unlikely that in the foreseeable future all retarded pupils can be placed in auxiliary or special classes, as there will doubtless continue to be small schools serving areas of scattered population. Nevertheless, as one class could be found, on the average, among each 500 pupils, most of the forty-two towns and probably an equal number of municipal areas have sufficiently large numbers of pupils to require auxiliary classes. It is not known definitely how many areas have a sufficient number of trainable pupils to require a special class, but it is likely that there should be such a class in every centre of population having 2,000 people. In areas of sparse population, the children undoubtedly are present, but conveyance is frequently difficult for these pupils, so that they may be more properly educated in the Training School of the Department of Welfare. It is therefore clear that the educational program for retarded children in the public schools must



1 be greatly expanded before it will be close to providing  
2 adequately for the needs of all such children in Nova  
3 Scotia. The following aspects of the program require  
4 examination to see where they may be improved and thus  
5 contribute to better over-all results:

- 6 1) Financial assistance for classes for  
7 retarded pupils.
- 8 2) Training of teachers of retarded pupils.
- 9 3) Recognition of teachers employed by  
10 local Associations.
- 11 4) Prescribed courses for retarded pupils.
- 12 5) The supervision of classes for retarded  
13 pupils.

14 (1) FINANCIAL ASSISTANCE FOR RETARDED  
15 PUPILS

16 At present, classes for retarded pupils  
17 may be established at the option of local boards in the  
18 same way that regular classes are established as part of  
19 the foundation program, provided, in the case of train-  
20 able pupils, that there are ten such pupils to be en-  
21 rolled. This provision is fundamentally sound, and the  
22 government should be commended for making it. It is felt  
23 that the local authorities should continue to have the  
24 responsibility to decide whether or not classes should  
25 be formed. Before coming to this decision the Associ-  
26 ation discussed at some length the desirability and  
27 feasibility of having the classes made mandatory for  
28 school boards, and decided that at this time it should  
29 not make such a recommendation. It should be pointed  
30 out that in 1947 the State of California made special







1 education mandatory for all educable retarded pupils of  
2 school age, and the State agreed to reimburse the schools  
3 for the excess over normal operating costs that such pro-  
4 grams would entail. This principle has now been adopted  
5 by most states in the United States.

6                   There are two ways in which the government  
7 could assist further in providing financial assistance  
8 for the education of retarded children that would be very  
9 helpful in extending and improving the program. These  
10 are, first, to provide a grant, payable to local branches  
11 of the Nova Scotia Association for retarded children, to  
12 assist in the operation of approved classes for trainable  
13 retarded children operated by the Association in areas  
14 where the school boards do not provide such classes, and  
15 second, to permit conveyance to be provided by school  
16 boards under the foundation program for mentally retarded  
17 pupils, regardless of how far from school they live.

18 Grants to Local Branches of the Association

19                   The Nova Scotia Association recommends  
20 that the Department of Education should pay an annual  
21 grant to local Branches of N.S.A.R.C. which operate ap-  
22 proved classes for trainable retarded children in an area  
23 where the school board does not provide any classes.

24                   The following points are advanced in sup-  
25 port of this proposal:

26                   a) Parents of retarded pupils are taxed,  
27 as are all citizens, to pay the general costs of edu-  
28 cation, yet their children receive no benefits if they  
29 live in an area where no class has been established.

30                   b) The Government provides free education







1 and accommodation for retarded children at the N.S.  
2 Training School at Truro, at a cost per pupil greatly in  
3 excess of the cost of providing for them in the public  
4 schools. ~~If~~ adequate provision is made for these pupils  
5 in the public schools, the size of the training school  
6 may be smaller than otherwise ~~would~~ be.

7 c) The Association is willing to have, and  
8 indeed would welcome having, such classes inspected and  
9 supervised by the Department of Education.

10 d) A grant of this nature would be of great  
11 assistance and encouragement to Associations to begin  
12 classes in areas where there are not enough trainable  
13 children to permit a board to establish a class, or where  
14 the board is unwilling to establish a class.

15 e) In order to find out what assistance  
16 is given by Departments of Education across Canada for  
17 the education of retarded children three questions were  
18 sent to the Deputy Minister of Education for each province.  
19 The questions and the range of answers received to them  
20 are given below. A more detailed summary of the answers  
21 may be found in Appendix B.

22 Question 1: What financial assistance is given to school  
23 boards that arrange for special classes for  
24 retarded children?

25 Answers: Most Departments of Education assist school  
26 boards to operate classes for educable  
27 retarded pupils in the same way and to the  
28 same extent as they assist for regular classes.  
29 This means that the cost per pupil is higher  
30 for these pupils, as the enrollment is





generally considerably lower.

Question 2:

What financial assistance is given to voluntary groups who arrange for the education of retarded children?

Answers:

All Provinces except Quebec assist to some extent. In Saskatchewan the grant is not paid directly to a voluntary agency, but to a special board, which has representatives on it from the regular board, voluntary groups, and the Department of Education.

The amount of the grant varies from the regular help given all classes (P.E.I.) to \$50.00 per month per pupil, full day basis, or \$25.00 per month per pupil half-time basis (Ontario).

Question 3:

What are the conditions under which the financial assistance mentioned in the first two questions is given to the parties concerned?

Answers:

Generally, the Government maintains some control over admission to the class, inspection of the program, and the qualifications of the teacher, through the inspection staff of the Department of Education, medical health officers, or otherwise.







(2) TRAINING OF TEACHERS OF  
RETARDED CHILDREN

At the present time, most of the teachers of auxiliary classes in the public schools have general licenses. Six teachers of retarded children have special auxiliary class licenses and two teachers of special classes have permits to teach.

The Association feels that teachers of retarded children should have a general license and some experience teaching normal children followed by special training for their work with retarded children. It follows that the present method of granting a general license after a year at the Provincial Normal College, and a special license in auxiliary education after the completion of a four session "block" program at the Nova Scotia Summer School provides very good facilities for teachers, and the Association would like to see them continued.

If the number of classes for retarded children increases as the Association feels it should, it appears that a special two year course for teachers of retarded pupils should be established at the new Teachers College in Truro. It is suggested that this be done in such a way that teachers may qualify for a general license in one year and for the specialist license in two years. This would enable teachers with general licenses willing to take a year off from teaching to attend the Teachers College and qualify for a specialist license.

A question related to the availability of







1 training facilities and courses is the supply of candi-  
2 dates for the special training. This has been and continues  
3 to be a problem, even though the demand for such teachers  
4 is not as great as it should and presumably will be.  
5 This appears to be part of the general problem of teacher  
6 supply and will probably not ease off until the number  
7 of teachers available for all positions is at least equal  
8 to the demand. While there are undoubtedly many causes,  
9 it is suggested that the most important one is that the  
10 foundation scale of teachers' salaries is inadequate to  
11 attract sufficient numbers to the special classes.

12  
13 (3) RECOGNITION OF TEACHERS  
14 EMPLOYED BY LOCAL ASSOCIATIONS

15 At present teachers employed by local  
16 Associations are not classed as teachers for purposes of  
17 the Nova Scotia Teachers' Pension Act, nor is the time  
18 they spend in such a position recognized as service time  
19 for salary purposes. Accordingly these positions are  
20 not attractive to regularly licenced teachers.

21 It is therefore recommended that qualified  
22 teachers employed by local Associations of the N.S.A.R.C.  
23 to teach recognized classes of retarded children be  
24 classed as teachers under the Nova Scotia Teachers'  
25 Pension Act, and that the time they spend in the employ  
26 of such boards be recognized for salary purposes by the  
27 Department of Education.

28 (4) PRESCRIBED COURSES  
29 FOR RETARDED PUPILS

30 At the present time the Department of  
Education does not supply teaching guides for auxiliary





1 or special classes, with the result that the programs  
2 followed are left entirely to the local authorities. In  
3 some cases the people responsible have devised very good  
4 programs, but it is suggested that teaching guides which  
5 would be available for all classes would be very helpful.  
6 This is especially true at the present time when many of  
7 those teaching the classes have not had special training  
8 in the work they are doing. It is recommended, therefore,  
9 that teaching guides for both auxiliary and trainable  
10 classes be prepared and distributed by the Department of  
11 Education. The Association has prepared a manual, giving  
12 information on the procedure to follow in forming a  
13 branch Association and general suggestions for a cur-  
14 riculum for trainable pupils, which it believes would  
15 be useful as a starting point in preparing a teaching  
16 guide. This manual, for which the Department of Education  
17 paid the cost of publication has proved to be helpful to  
18 teachers, but it should be revised and expanded.

19 (5) THE SUPERVISION OF CLASSES FOR RETARDED  
20 CHILDREN

21 The education of retarded pupils in Nova  
22 Scotia requires the direction of one person with special  
23 training and the appropriate personal qualities of  
24 sympathy for and understanding of the problems involved  
25 together with the enthusiasm and energy to put them into  
26 effect. So long as this important phase of education is  
27 just one of the many duties of busy people, even though  
28 they may be interested, it will not get the attention it  
29 merits. Consequently the Association was very pleased  
30 indeed to hear that an inspector of Special Education





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3 some cases the people responsible have devised very good  
4 programs, but it is suggested that teaching guides which  
5 would be available for all classes would be very helpful.  
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7 those running the classes have not had special training  
8 in the work they are doing. It is recommended, therefore,

9 that teaching guides for both primary and secondary  
10 classes be prepared and distributed by the Department of

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13 Branch Association and general suggestions for a cur-  
14 riculum for possible pupils, which it believes would  
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27 just one of the many duties of busy people, even though  
28 they may be interested it will not get the attention it  
29 merits. Consequently the Association was very pleased  
30 indeed to hear that an Inspector of Special Education



1 will be appointed in the near future to direct and co-  
2 ordinate the educational program in special classes in-  
3 cluding those for retarded pupils. It is to be hoped  
4 that the appointment will be made as soon as possible.

5 Summary of Recommendations

6 1) That a financial grant be paid to  
7 local branches of the Nova Scotia Association for Re-  
8 tardated Children for each pupil who attends an approved  
9 class for trainable pupils operated by the Association,  
10 when the school board does not provide such a class.

11 2) That school boards be permitted to pro-  
12 vide conveyance for mentally retarded pupils on the same  
13 basis as for physically handicapped pupils, regardless  
14 of how far they live from school.

15 3) That the present block program to  
16 qualify for a specialist teacher's license in auxiliary  
17 education be continued at the Nova Scotia Summer School.

18 4) That a two year program to qualify for  
19 a specialist teacher's license be established at the  
20 Nova Scotia Teachers' College.

21 5) That qualified teachers employed by  
22 local Asscciations of the N.S.A.R.C. to teach recognized  
23 classes of retarded children be classed as teachers under  
24 the Nova Scotia Teachers' Pension Act, and that the time  
25 they spend in the employ of such boards be recognized  
26 for salary purposes by the Department of Education.

27 6) That teaching guides for auxiliary  
28 classes and special classes be prepared and distributed  
29 by the Department of Education.  
30

will be appointed in the near future to direct and co-ordinate the educational program in special classes including those for retarded pupils. It is to be hoped that the appointment will be made as soon as possible.

Summary of Recommendations

- 1) That a financial grant be paid to local branches of the Nova Scotia Association for Retarded Children for each pupil who attends an approved class for trainable pupils operated by the Association, when the school board does not provide such a class.
- 2) That school boards be permitted to provide conveyances for mentally retarded pupils on the same basis as for physically handicapped pupils, regardless of how far they live from school.
- 3) That the present blind program be qualify for a specialist teacher's license in auxiliary education be continued at the same rate in Summer School.
- 4) That a two year program be qualify for a specialist teacher's license be established at the Nova Scotia Teachers' College.
- 5) That qualified teachers employed by local Associations of the N.S.A.R.C. to teach retarded classes of retarded children be classed as teachers under the Nova Scotia Teachers' Pension Act, and that the salary they spend in the salary of such boards be recognized for salary purposes by the Department of Education.
- 6) That teaching guides for auxiliary classes and special classes be prepared and distributed by the Department of Education.





7) That the appointment of an Inspector of Special Education, recently authorized by the Minister of Education, be made as soon as possible.

#### DIAGNOSTIC AND COUNSELLING CLINICS

When a child is observed to be developing at a slower rate than other children of the same age, the prime necessity is for an adequate examination to be carried out, in order that an early diagnosis may be made of the causes of his retardation, and steps taken to prevent further deterioration and to ensure his development under the best possible conditions. Such an examination is of benefit not only to the child himself, but in the early stages perhaps even more so to the parents and to those responsible for the future care of the child.

Such an examination should include physical, mental, and psychological testing, and in most instances will call for the services of an efficient and devoted team, including the family physician, a pediatrician, a psychiatrist, a psychologist, a speech therapist, and social workers. Their combined efforts will be necessary in order to determine the presence and relative importance of physical or mental illness or mental deficiency in each individual case.

Once the diagnosis has been established, careful professional supervision of the appropriate course of action is necessary, and throughout the life of the individual concerned the parents or guardians are in continual need of counsel and advice, which can only be provided by those trained and experienced in the field of retardation.

7) That the appointment of an Inspector of Special Education, recently authorized by the Minister of Education, be made as soon as possible.

# DIAGNOSTIC AND COUNSELLING CLINICS

When a child is observed to be developing at a slower rate than other children of the same age, the primary necessity is for an adequate examination to be carried out, in order that an early diagnosis may be made of the causes of his retardation, and steps taken to prevent further deterioration and to ensure his development under the best possible conditions. Such an examination is of benefit not only to the child himself, but in the early stages perhaps even more so to the parents, and to those responsible for the future care of the child. Such an examination should include physical, call, mental, and psychological testing, and in most instances will call for the services of an efficient and devoted team, including the family physician, a pediatrician, a psychologist, a psychiatrist, a speech therapist, and social workers. Their combined efforts will be necessary in order to determine the presence and relative importance of physical or mental illness or mental deficiency in each individual case. Once the diagnosis has been established, careful professional supervision of the appropriate course of action is necessary, and throughout the life of the individual concerned the parents or guardians are in continual need of counsel and advice, which can only be provided by those trained and experienced in the field of research.



Such diagnostic and counselling facilities can most appropriately be provided by a clinic organized for the purpose, and such total coverage is not currently available at any centre in Nova Scotia, although some valuable services are being provided by the Child Guidance Clinic in Halifax, and by Mental Health Clinics in various centres in the Province.

The Nova Scotia Association for Retarded Children is recommending to the Provincial Government that a Diagnostic and Counselling Clinic for the mentally retarded, following the broad principles outlined above, should be established in the Halifax-Dartmouth area, with appropriate financial support, largely from Federal and Provincial grants.

The presence of such a diagnostic and counselling clinic in Halifax would in no way reduce the necessity for similar facilities in other areas in the Province, but could provide additional services, including professional consultations with the fields of neurology, neurosurgery, ophthalmology, orthopedics, cardiology, dentistry, etc., and could provide material for the medical and social research so necessary in order to overcome this major problem of mental retardation.

Such valuable guidance is available from the printed reports of the activities of similar clinics in other centres of North America, including two in Canada.

The appropriate place for such a clinic might be the proposed Out-Patient Department of the new Halifax Children's Hospital, (in which the professional consultants detailed above would be readily available),







1 but until that out-patient building comes into being  
2 it is understood that space is available within the Dal-  
3 housie Public Health Clinic.

4 Such a diagnostic and counselling clinic  
5 will necessitate a large budget, including capital ex-  
6 penditure for buildings, moderate expenditure for equip-  
7 ment, and major expenditure for salaries for full-time  
8 and part-time professional personnel. While a large part  
9 of this expenditure must of necessity come from federal  
10 and provincial funds, it would seem appropriate that some  
11 assistance should be sought from university funds, and  
12 that a considerable part of the cost should be met from  
13 private sources, at least in the initial stages of oper-  
14 ation of the clinic. It is understood that the Provincial  
15 Chapter of the Imperial Order of the Daughters of the  
16 Empire is prepared to make a substantial grant to  
17 N.S.A.R.C. for the purpose of setting up such a clinic  
18 in the Halifax-Dartmouth area.

19 Since numerous requests for help are re-  
20 ceived from parents of retarded children residing in  
21 various parts of the Province, and since such parents  
22 not infrequently require advice as to the care of their  
23 retarded children in the home, there is an apparent need  
24 for an expanded home counselling service, and it is sub-  
25 mitted that this could appropriately be directed by  
26 adequately trained workers attached to the Mental Health  
27 Clinics. The proposed Diagnostic and Counselling Clinic  
28 in the Halifax-Dartmouth area should provide such service  
29 in that part of the Province, and could also act as a  
30 clearing house for requests received from parents and  
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SUMMARY OF RECOMMENDATIONS

That a Diagnostic and Counselling Clinic for the mentally retarded and their parents be established in the Halifax-Dartmouth area.

OCCUPATIONAL AND VOCATIONAL TRAINING AND EMPLOYMENT OPPORTUNITIES

80% of the adult mentally retarded can be completely or partially self-supporting if employment opportunities are available in the communities in which they live. Since by far the greatest number of the retarded are in the intelligence quotient level of 50 to 75%, a correspondingly large proportion can provide for themselves and their families under favorable circumstances, thus avoiding the necessity for financial assistance from public or private funds. This employment potential is not being realized in Nova Scotia, since the training facilities and vocational opportunities are not available, except to the most limited degree.

TRADES TRAINING

Our Association was pleased to learn that the Provincial Government is establishing a trade school in the Halifax area, and is planning to do so in other regions of the Province. Many of the adult retarded need the type of instruction provided by such a school, but may be denied such instruction if the entrance requirements for such schools are of a higher academic standard than they can attain. There has apparently been some criticism directed at the school system by the unemployment authorities because of the large number of children leaving school with no greater than grade VIII



There is a Diagnostic and Counseling Unit

for the mentally retarded and their parents be established

in the Halifax-Hammonds area.

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completely or partially self-supporting if employment opportunities are available in the communities in which they live. Since by far the greatest number of the retarded are in the intelligence quotient level of 70 to 75, a correspondingly large proportion can provide for

themselves, thus avoiding the necessity for financial assistance from public or private funds. This employment potential is not being realized in Nova Scotia, since the training facilities and vocational opportunities are not available, except to the most limited degree.

Our Association has pleased to learn that the Provincial Government is establishing a trade school in the Halifax area, and its plan to do so in other regions of the Province. Many of the adult retarded need the type of instruction provided by such a school, but may be denied such instruction if the standards for such schools are of a higher academic standard than they can attain. There has apparently been some criticism directed at the school system by the unemployed authorities because of the large number of children leaving school with no greater than grade VII



1 education, but this relatively low standard of achieve-  
2 ment must be accepted as inevitable for 20% of children  
3 attending school.

4 The Provincial Government is therefore  
5 requested:

6 1) To permit the acceptance of students into the trade  
7 schools on the recommendation of teachers, rather than  
8 insisting on grade IX or grade X certificates in all  
9 cases.

10 2) To include more courses in trade schools at the semi-  
11 skilled level to accommodate the 20% who cannot attain  
12 the higher level of vocational skills.

13 3) If because of limitations of space or for other reasons  
14 the moderately retarded adults cannot be accommodated in  
15 the trade schools, it is requested that alternative trade  
16 training facilities be made available. It is pointed  
17 out, however, that the provision of such additional  
18 facilities may prevent the most economical use of avail-  
19 able buildings and instructors.

20 SHELTERED WORKSHOP

21 Many adults who are physically handicapped  
22 are unable to absorb vocational training at the same pace  
23 as those who are physically normal, and cannot produce  
24 to their full potential while it is necessary to meet a  
25 deadline. With careful supervision, such as in a re-  
26 habilitation centre, these individuals can gradually  
27 attain the necessary level of skill before entering (or  
28 returning to) normal industrial life. The mentally  
29 handicapped can profit from a similar programme of re-  
30 habilitation, and the value of sheltered workshops for



education, but this relatively low standard of achievement must be accepted as inevitable for 30% of the population.

The Provincial Government is therefore

requested:

1) To permit the acceptance of students into the trade schools on the recommendation of employers, rather than insisting on grade IX or grade X certificates in all cases.

2) To include more courses in trade schools at the semi-skilled level to accommodate the 20% who cannot attain the higher level of vocational skills.

3) If because of limitations of space or for other reasons the moderately retarded adults cannot be accommodated in the trade schools, it is requested that alternative classes training facilities be made available. It is pointed out, however, that the provision of such additional facilities may prevent the most economical use of available buildings and instructors.

Many adults who are physically handicapped are unable to receive vocational training at the same pace as those who are physically normal, and cannot progress to their full potential while it is necessary to meet a deadline. With careful supervision, such as in a rehabilitation center, these individuals can gradually attain the necessary level of skill before entering (or returning to) normal industrial life. The mentally handicapped can benefit from a similar programme of rehabilitation, and the value of sheltered workshops for



1 the retarded has been amply demonstrated in many parts  
2 of the world.

3 During 1960 a sheltered workshop known  
4 as "New Leaf Enterprises" began operation in Halifax,  
5 with the financial support and supervision of the Junior  
6 League of Halifax and the Poliomyelitis Foundation.  
7 This sheltered workshop provided the opportunity for the  
8 handicapped of many types, including the mentally retard-  
9 ed, to learn or re-learn a trade under conditions free  
10 from competitive stress, (thus providing the adult  
11 equivalent of the special classes for children). This  
12 project, although in operation for only a few months,  
13 already promises to be of great value to the adults re-  
14 tardated, and an expansion of this service, catering to the  
15 mentally retarded alone, will shortly be operating in  
16 the Halifax area, financed jointly by the Halifax School  
17 Board and the Vocational Educational Division of the  
18 Provincial Department of Education.

19 After such training, the majority of  
20 these young men and women will be ready for employment  
21 outside the Sheltered Workshop, but in addition some  
22 adults will be employed on suitable work undertaken with-  
23 in the Workshop on a contract basis. It is not antici-  
24 pated that those employed on this contract work will be  
25 completely self-supporting, and they will thus require  
26 a partial subsidizing from other sources. It is re-  
27 quested that the creation and financial support of such  
28 sheltered workshops in various centres of the Province  
29 become a responsibility of the Provincial Government,  
30 through the Rehabilitation Branch of the Department of  
Public Health.







1 JOB PLACEMENT OFFICER

2 A large number of adult retarded in our  
3 Province, many of them graduates of the auxiliary classes,  
4 are being supported by public funds or by their families  
5 from the time they leave school until they die, despite  
6 the fact that almost all the educable retarded, and the  
7 majority of the trainable retarded, are capable of sup-  
8 porting themselves, either wholly or in part. This  
9 waste of manpower, and in many cases waste of public  
10 money, has existed in our Province despite the many  
11 favorable reports of the work of the moderately retarded  
12 adult employed in industry in Great Britain, Continental  
13 Europe, and the United States.

14 In an effort to correct this situation,  
15 the Halifax and Dartmouth Branches of N.S.A.R.C., sup-  
16 ported by the United Commercial Travellers Association  
17 of Halifax, a few months ago engaged a Job Placement  
18 Officer to arrange for employment for the adult retarded  
19 of this area. This officer, with knowledge of the  
20 capacity of the young people concerned, was able to ob-  
21 tain suitable employment for a significant number in her  
22 first six months of operation. Her duties have included  
23 guidance and counsel to the employees during their first  
24 weeks on the job.

25 The results of this pilot project have been  
26 most gratifying, to employers as well as employees. Not  
27 only have many mentally handicapped achieved the dignity  
28 of labor and financial remuneration after many years of  
29 enforced idleness, but their record of faithful service  
30 and their unusually low absenteeism, have compared most





1 favorably with those of the average employee of full  
2 intellect. It is a matter of considerable interest that  
3 in the United Kingdom during the past few years it has  
4 become law that in any industry employing more than 100  
5 workers, 20% of them must be handicapped. This 20% in-  
6 cludes a large number of the mentally retarded, and it  
7 has been found that this legislation results in a great  
8 saving of public money, which would otherwise be expend-  
9 ed on relief and pensions.

10 It is, therefore, requested that the Job  
11 Placement Officer project be considered a demonstrated  
12 necessity by the end of its first year of operation in  
13 August 1961, and that the Provincial Government, through  
14 the Rehabilitation Branch of the Department of Public  
15 Health, assume responsibility for this project at that  
16 time, finding necessary grants to maintain and expand  
17 this essential service for the future. Further, that  
18 other Job Placement Officers for the mentally retarded  
19 be appointed in various localities of the Province as  
20 the need arises.

21 SUMMARY OF RECOMMENDATIONS

- 22 (1) a) That students be accepted into Trade  
23 Schools on recommendation of teachers.  
24 b) That courses for semi-skilled be  
25 included in Trades Schools curriculum.  
26 c) That if moderately retarded adults  
27 cannot be accommodated in Trades Schools,  
28 other training facilities be made  
29 available.  
30







(2) That Sheltered Workshops for the mentally retarded be established with Provincial Government support.

(3) That the Job Placement Officer in the Halifax - Dartmouth area be employed by the Provincial Department of Public Health with effect from August 1, 1961, to continue full-time work with retarded adults.

#### MEDICAL RESEARCH

With increasing knowledge of the magnitude of the problem of mental retardation, and the encouraging results of early diagnosis and treatment, it is natural that there should have been a parallel of interest in medical research. The eventual objective of research is to facilitate prevention of the development of retardation, and its immediate application is the improvement of diagnostic and treatment methods.

At the Halifax Children's Hospital considerable original research is continuing, of a type not reproduced elsewhere in Canada, and Federal support for this has been obtained in the form of National Research Council Grants, Mental Health Grants, and the recent direct grant administered by the Nova Scotia Medical Society. If this Province is to continue to take the lead in this field of research it is essential that some beds be allocated for this purpose within the Halifax Children's Hospital. It is requested that the Provincial Government donate a sum sufficient to provide

(2)

(3)

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retarded be established with Provincial

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lead in this field of research it is essential that  
Halifax Children's Hospital. It is requested that the  
Provincial Government donate a sum sufficient to provide





1 for from four to six beds in the proposed New Children's  
2 Hospital, for the sole purpose of investigation of  
3 mentally retarded children.

4 The Provincial Government of Ontario has  
5 donated sufficient funds to include an extra 20 to 30  
6 beds at the New Children's Hospital in London, Ontario  
7 for the sole purpose of research on mental retardation.

8 SUMMARY OF RECOMMENDATIONS

9 That the Provincial Government finance  
10 4 - 6 beds in the proposed new Halifax Children's Hospital  
11 for the sole purpose of medical research into mental  
12 retardation.

13  
14 SPECIAL TREATMENT FOR PHENYLPYRUVIC OLIGOPHRENIA ("P.K.U.  
DISEASE")

15 The rare disease called phenylpyruvic  
16 oligophrenia is due to an inherited biochemical defect  
17 which results in progressive mental retardation, which  
18 begins shortly after the child is born. If the condition  
19 is recognized within the first ten or twelve weeks of  
20 life and the child is placed on a special diet (avail-  
21 able commercially) the mental retardation may be pre-  
22 vented.

23 Arrangements are now being completed,  
24 under the direction of Dr. William A. Cochrane, Associate  
25 Professor of Paediatrics, Dalhousie University, for the  
26 testing of all new-born children in Nova Scotia in order  
27 to detect this disease in its very early stages, so  
28 that the appropriate treatment may be instituted. Once  
29 the disease has been diagnosed, the cost of the necessary  
30 diet is from \$2,000 to \$2,500 annually, and it is likely





1 that it must be maintained for about the first years of  
2 the child's life.

3 (However, after the first year the diet is adjusted and  
4 its annual cost for the second and third years will be  
5 approximately one-half of the cost for the first year.)

6 It is requested that the Provincial Government  
7 assume the cost of this dietary treatment to such  
8 patients, since it is beyond the means of most families.  
9 It is estimated that from two to three new cases of this  
10 disease will be diagnosed annually in Nova Scotia.

11 It should be pointed out that this dis-  
12 ease, if untreated, results in severe mental retardation,  
13 and it has been estimated that the eventual cost of  
14 custodial care etc. will be from \$50,000 to \$100,000 per  
15 patient. It can thus be clearly seen that even if only  
16 the economic aspect is considered, it is a great saving  
17 of public money to assist in preventing the development  
18 of mental retardation in these children.

19 The Provincial Governments of Ontario,  
20 Alberta, and New Brunswick have agreed to finance the  
21 diet of any patient found with this disease, and the same  
22 step is being considered by the Government of Manitoba.

### 23 SUMMARY OF RECOMMENDATIONS

24 That the Provincial Government assume the  
25 cost of dietary treatment of cases of phenylpyruvic  
26 oligophrenia diagnosed in Nova Scotia.

### 27 THE DELINQUENT RETARDED

28 This brief would not be complete if it  
29 neglected to include a reference to the treatment of the  
30







1 retarded in our Courts.

2 Although the law is a Federal matter, the  
3 administration of justice in Nova Scotia is in the hands  
4 of the Attorney General's Department, and based on cases  
5 which have come to our attention, we suggest that in some  
6 areas of the Province, at least, the Courts have not  
7 considered the mental condition of the accused prior to  
8 passing sentence.

9 Elsewhere in this brief we have given a  
10 definition of mental retardation, but suffice to say here  
11 that persons suffering from this condition have less  
12 than normal intelligence. It is obvious that for this  
13 reason some of our juvenile and adult retardates are more  
14 easily led and influenced by the less responsible ele-  
15 ments in our Society, and, therefore, on occasion find  
16 themselves outside the law. In addition, the lack of  
17 proper educational facilities, and the poor employment  
18 possibilities for the retarded, combine with a sense of  
19 frustration to make these individuals more susceptible  
20 to violations of one kind or another.

21 In many cases, at present, the retardate  
22 who is charged with a criminal offense is sent to jail  
23 and/or penitentiary, which in some instances is grossly  
24 unjust, as many of them are, in fact, not responsible for  
25 their actions, and should be treated accordingly. It  
26 should be made clear that we are not excusing either  
27 criminal acts or anti-social behaviour on the part of the  
28 retarded, but wish to ensure fair treatment in our Courts.  
29 It is submitted that the sentence should fit both the  
30 individual and the crime.

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In many cases, at present, the retarded who is charged with a criminal offense is sent to jail and/or penitentiary, which in some instances is grossly unjust, as many of them are, in fact, not responsible for their actions, and should be treated accordingly. It should be made clear that we are not exempting either criminal acts or anti-social behaviour on the part of the retarded, but wish to ensure fair treatment in our Courts. It is submitted that the sentence should fit both the

individual and the crime.





It is suggested that implementation of the following recommendations would help to alleviate the present unsatisfactory situation:

RECOMMENDATIONS:

- 1) Probation officers be appointed to serve each Court in the Province. There is a lack of such personnel at present.
- 2) In all cases where there is any indication that a guilty person is retarded, the Court should be furnished with a Pre-Sentence Report by the Probation Service Department. This report would include a review of the family background, the school and work record of the prisoner, and the degree of his or her mental disability based on the results of proper psychological testing.
- 3) All Court officials in the Province should be encouraged to work closely with the Probation Service at all times, but particularly when dealing with prisoners who have been classed as retarded. Persons who have been diagnosed as mildly or moderately retarded should be remanded in the custody of the Probation Officer under whose guidance - and with the assistance of our own organization - suitable treatment and counselling could be given, and eventual employment located.
- 4) On the recommendation of the Attorney General's Department, the seriously retarded should be committed to institutions of the type outlined elsewhere in this brief.

It is suggested that implementation of the following recommendations would help to alleviate

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4) On the recommendation of the Attorney

General's Department, the seriously retarded should be

committed to institutions of the type outlined elsewhere

in this report.



1 SUMMARY

2 of 1972-73 The rights of the retarded would be more  
3 adequately safeguarded if instead of being confined to  
4 penal institutions they were placed in the custody of  
5 the Provincial Probation Service Department. This  
6 recommendation would necessitate the appointment of a  
7 sufficient number of Probation Officers to serve all  
8 courts in the Province, and it is assumed that these  
9 officials would receive adequate training in the handling  
10 of the retarded.

11 CONCLUSION

12 This presentation, though broad in scope,  
13 is not intended to suggest means of providing for all the  
14 needs of the mentally retarded of Nova Scotia, nor does  
15 it indicate the present or projected limits of activity  
16 of our Association. Above all, it should not be inter-  
17 preted as a statement that the parents of the retarded  
18 consider that the whole responsibility for the care of  
19 our children rests with the Provincial Government, or  
20 governments at any level. Rather it is intended to  
21 indicate the ways in which it is considered appropriate  
22 for the Provincial Government, because of its special  
23 powers and privileges, to undertake a greatly expanded  
24 programme of aid and encouragement to the mentally re-  
25 tardated of all ages.

26 The parents and friends of the retarded  
27 fully realize their own responsibilities in providing  
28 for these "permanent children" and handicapped adults,  
29 and in the past 4-5 years, through the various branches  
30







1 of the Provincial Association, have initiated a number  
2 of projects, which have attracted the interest and sup-  
3 port of a large segment of the population, and have been  
4 sustained through the generosity of Service Clubs,  
5 Welfare Organizations, Women's Groups, Business Houses,  
6 Labour Organizations, and many individuals, both lay  
7 and professional. During these early years our members  
8 have in addition been inspired by the guidance and as-  
9 sistance afforded by devoted professional people active  
10 in Provincial and Local Governments, in the fields of  
11 education, welfare and health.

12 Included in the measures which have been  
13 successfully launched as a result of this voluntary  
14 effort are: -

15 1) Special Classes for the Trainable

- 16 a) Selection of pupils  
17 b) Provision of classroom space and materials  
18 c) Payment of teachers.

19 (N.B. In some areas the above responsi-  
20 bilities have now been assumed by local  
21 School Boards, who have accepted these  
22 special classes into the regular school  
23 systems).

- 24 d) Transportation of pupils  
25 e) ~~Preparation~~ Preparation of a Manual (by the Education  
26 Committee of N.S.A.R.C.) containing cur-  
27 riculum and other suggestions for the  
28 guidance of those setting up such special  
29 classes.

30 2) Grants towards expenses of teachers attending







1 Summer School courses of the four-year "block  
2 training plan"

3 3) Recreation facilities for retarded children and  
4 adults, (including three summer camps)

5 4) Research

6 Financial assistance to a Research Fellow at  
7 the Halifax Childrens' Hospital

8 5) Sheltered Workshop

9 Participation in activities of "New Leaf  
10 Enterprises"

11 6) Vocational and Occupational Training

12 Classes soon to be in operation in the Halifax  
13 area

14 7) Employment Opportunities

15 Through the "Job Placement Officer"

16 8) Diagnostic and Counselling Clinic

17 Funds available towards setting-up of such a  
18 clinic in the Halifax area.

19 9) Public Education

20 Speakers to Service Clubs, Womens' Organizations,  
21 Home and School Associations, Religious Groups,  
22 etc.

23 Press, Radio and Television publicity

24 Dissemination of information to Local Associations,  
25 parents, teachers, and interested individuals.

26 10) Participation in activities of Canadian  
27 Association for Retarded Children

28 Delegates to all national conventions

29 N.B. The Fifth Annual Meeting of C.A.R.C. and Confer-  
30 ence on Mental Retardation is to be held in Halifax in 1962.





1 It should be noted that N.S.A.R.C. and  
2 its local associations employ no paid secretarial or  
3 executive assistance and maintain no office-headquarters,  
4 although it is apparent such will be necessary in the near  
5 future.

6 No direct financial grants have been  
7 applied for or received by N.S.A.R.C. or its member  
8 associations from governments at any level.

9 No organized financial appeal to the public  
10 has as yet been made by our member associations, although  
11 such an appeal will probably be made during the Fall of  
12 1961. Fund-raising to date has been by means of grants  
13 and donations from Service Clubs and similar organi-  
14 zations, by tag days, fashion shows, sale of Christmas  
15 cards, and similar small-scale efforts. (One local as-  
16 sociation, in Pictou County, participated in the United  
17 Appeal in 1961).

18 - - - - -  
19

20 When the recommendations contained in  
21 this brief have been implemented our Association will  
22 still have a major role in the care and development of the  
23 retarded child and adult, since it is by no means con-  
24 sidered appropriate that Governments and public funds  
25 should assume the privileges and responsibilities which  
26 rightly belong to the voluntary associations, informed  
27 individuals, and their personal resources. The principal  
28 function of the parents of mentally handicapped children  
29 will be to provide continuing education of the public  
30 in order that their elected representatives may receive







1 the necessary support in the enactment of legislation and  
2 expenditure of public money.

3 In addition, our local associations and  
4 public-minded citizens will expect to make appropriate  
5 contributions to the support of the projects here des-  
6 cribed, and to other similar activities not detailed in  
7 this submission.







APPENDIX A

Nova Scotia Association for Retarded Children

Aims and objects of Organization

The Association is a non-profit, non-sectarian and non-political organization taking no position in public affairs except with regard to those matters concerning mental retardation. The following are the means through which the Association intends to attain its objects:-

- (a) By fostering mutual help and co-operation among all those entrusted with the care of the mentally retarded; by encouraging the formation of parents' groups and local associations and by co-ordinating their activities.
- (b) By furthering research on all aspects of mental retardation.
- (c) By developing a better understanding of the problems of mental retardation by the general public.
- (d) By co-operating with all public and private agencies, both national and international, and with federal, provincial and local authorities in furthering the cause of mentally retarded everywhere.
- (e) By furthering the training and education of personnel for work in the field of mental retardation.
- (f) By furthering the implementation of legislation on behalf of the mentally retarded and by promoting the enactment of legislation which will improve their status.
- (g) By encouraging the establishment and maintenance of clinics, schools, homes, hostels, hospitals,





1 institutions, workshops, training centres, employment  
2 centres and other places in connection with the further-  
3 ance of the objects of the Association.

4 (h) By serving as a clearing house for  
5 gathering and disseminating information regarding the  
6 mentally retarded and by fostering the development of  
7 integrated programs on their behalf.

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APPENDIX B

QUESTIONS ASKED AND SUMMARIES OF THE ANSWERS RECEIVED  
FROM THE DEPARTMENT OF EDUCATION IN CANADA REGARDING THE  
EDUCATION OF RETARDED CHILDREN

---

Question 1: What financial assistance is given to  
school boards that arrange for special  
classes for retarded children?

Answers: Newfoundland The Department gives no  
financial assistance to School Boards at  
present.  
Prince Edward Island Pays to school boards  
who arrange for special classes for re-  
tarded children that portion of a teach-  
er's salary for which they are normally  
responsible. The grant is based on the  
class of license held by the teacher and  
her years of teaching experience. Usually  
the assistance is in the vicinity of 60 -  
70% of the yearly salary of the teacher.  
New Brunswick Pays to school boards for  
each opportunity class (auxiliary class)  
\$100 per year in addition to grants  
normally paid for regular classes. Pays  
\$100 to a teacher who attends summer  
classes in auxiliar education.  
Quebec For several years a grant of  
\$10,000 has been paid to the School Board  
of Greater Montreal for the education of  
children - I.Q. below 90 -- in 32 classes  
operated at present by this Board. The



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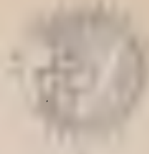


1 situation is not satisfactory outside Greater  
2 Montreal where Boards do not receive any addition-  
3 al assistance for these classes, other than the  
4 normal assistance which is dependent on the  
5 number of pupils being educated. Only a few  
6 Boards outside Greater Montreal operate these  
7 classes because of difficulties of satisfactory  
8 teaching personnel. Small numbers of low I.Q.  
9 in relation to the total number of pupils and  
10 problems of finance.

11 Ontario School boards receive assistance for  
12 the financing of auxiliary classes on the same  
13 basis as they do for regular classes.

14 Manitoba School boards which operate classes  
15 for retarded (educable) receive a teacher grant  
16 equal to that of the teacher of a regular class.  
17 The amount of the teacher grant is, of course,  
18 dependent on the teacher's qualifications, and  
19 in the case of retarded students, is paid for  
20 a smaller number of pupils. A minimum of ten  
21 pupils is required to establish a class that will  
22 qualify for a grant. If there are more than  
23 one class a class qualifying for a grant may be  
24 established for each fifteen pupils.

25 Saskatchewan For educable retarded classes  
26 \$2.00 per day per room in addition to the grant  
27 for regular classes. For trainable retarded  
28 classes, a capital grant of \$5.25 per square foot  
29 of approved space, and an operational grant of  
30 \$2500 per year plus whatever equalization grant



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qualify for a grant. If there are more than  
one class a class qualifying for a grant may be  
established for each fifteen pupils.

Saskatchewan For educable retarded classes  
\$2.00 per day per room in addition to the grant  
for regular classes. For trainable retarded  
classes, a capital grant of \$2.25 per square foot  
of approved space, and an operational grant  
\$2.00 per year plus whatever educational grant



1 a room could earn if it operated as a one-room  
2 rural school. The latter has varied from \$40.00  
3 to \$1300.00.

4 Alberta The Provision of education for

5 "educable" retarded children comes under the  
6 regular Grant requirements. However, in ad-  
7 dition, a grant of \$2500 per teacher is paid.

8 British Columbia Approved "special classes"

9 enrolled in the public schools, whether for very  
10 slow learners or mentally retarded pupils, are  
11 treated in the same way as any other class. The  
12 teacher is recognized as within entitlement for  
13 basic grant purposes. The pupils she enrolls  
14 are not counted in the general enrolment of the  
15 school. Operating expenses are subject to the  
16 same grants as those of any other class in the  
17 school. In other words, the teacher and the  
18 class are recognized as integral parts of the  
19 school system and therefore of the grant  
20 structure. We avoid special grants in this way.

21 Question 2:

22 What financial assistance is given to voluntary  
23 groups who arrange for the education of retarded  
24 children?

25 Answers:

26 Newfoundland This year the Department carried  
27 in its vote an amount of \$70,000 in order for us  
28 to assist the Newfoundland Association for the  
29 Help of Retarded Children, a voluntary organi-  
30 zation which has several schools being conducted





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1 for this purpose.

2 Prince Edward Island Pays to voluntary groups  
3 who arrange special classes for retarded children  
4 that portion of a teacher's salary for which  
5 we are normally responsible. The grant is based  
6 on the class of license held by the teacher and  
7 her years of teaching experience. Usually the  
8 assistance is in the vicinity of 60 - 70% of the  
9 yearly salary of the teacher.

10 New Brunswick Pays to a society (defined as  
11 a duly incorporated association, a county school  
12 finance board, a board of trustees, or a person  
13 approved by the Lieutenant-Governor in Council)  
14 \$1000 for a class or classes conducted for  
15 mentally retarded children. \$500 for each teach-  
16 er engaged by the Society. \$100 for each pupil  
17 attending at least 40% of the courses conducted  
18 for such pupil during the period for which pay-  
19 ment is claimed. Pays to a teacher of mentally  
20 retarded class the regular grants paid to all  
21 teachers.

22 Quebec No assistance is given to voluntary  
23 groups who arrange for the education of retarded  
24 children.

25 Ontario The local branches of the Ontario  
26 Association for Retarded Children receive \$25.00  
27 per month for each pupil age 5 to 12 years in  
28 average daily attendance for one-half day, and  
29 \$50.00 per month for each pupil age 13 to 18  
30 years in average daily attendance for a full day.



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finance board, a board of trustees, or a person approved by the Lieutenant-Governor in Council) \$1000 for a class or classes conducted for mentally retarded children. \$500 for each pupil or engaged by the Society. \$100 for each pupil attending at least 40% of the courses conducted for each pupil during the period for which payment is claimed. Pays to a teacher of mentally retarded class the regular grants paid to all

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1 Manitoba Voluntary groups, i.e. the Association  
2 for Retarded Children receive, through the  
3 Department of Health and Welfare, a grant of  
4 \$20.00 per child per month (half-day basis) or  
5 \$40.00 per child per month (full-day basis).  
6 To qualify for grant purposes a child must attend  
7 80% of the time in any month.

8 Saskatchewan No help to a voluntary group as  
9 such. Grants are paid to special boards if they  
10 are approved by the Department of Education.  
11 These boards have representatives from local  
12 school boards, voluntary groups, and the  
13 Department of Education. Capital grants for  
14 new construction to such boards are the same as  
15 to regular boards for new construction. The  
16 operational grant to approved special boards  
17 is \$2500 per room per year.

18 Alberta The education of "severely" retarded  
19 children is not provided for by any school board  
20 in the Province. Ten such schools have been  
21 organized by the Alberta Association for Re-  
22 tarded Children. On behalf of any child en-  
23 rolled in one of the above schools, a school  
24 board is authorized to pay \$640 per school year  
25 of which amount the Department of Education will  
26 reimburse the board to the extent of 75% of the  
27 amount expended. School buildings of the  
28 Association are also supported by the Government.  
29 A grant equal to 90% of the total cost is paid  
30 provided, however, that such grant shall not

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1 exceed \$7200 per classroom nor 90% of the actual  
2 cost of the school.

3 British Columbia The only grants paid are through  
4 School Boards to the Association for Retarded  
5 Children of British Columbia on behalf of child-  
6 ren of school age attending schools operated by  
7 local chapters of the Association. The grant is  
8 150% of the net average annual operating cost  
9 per pupil enrolled in the public schools, calcu-  
10 culated on A.D.A. Right now, it amounts to \$473.  
11 43 per year per eligible child.

12 Question 3:

13 What are the conditions under which the financial  
14 assistance mentioned in the first two questions  
15 is given to the parties concerned?

16 Answers:

17 Newfoundland The conditions under which the  
18 financial assistance is given to the Association  
19 for the Help of Retarded Children are that the  
20 Association submit to the Minister of Education  
21 an outline of their proposal to set up a school  
22 together with costs, etc., of same. If the  
23 Association's proposals are acceptable they are  
24 advised to go ahead with the project and payments  
25 are made upon audited statements of their  
26 expenditure.

27 Prince Edward Island This assistance is paid  
28 provided that the school board or voluntary group  
29 concerned would first work out with the Department  
30 plans for the establishment of the class. There





exceed \$7500 per classroom nor 90% of the actual cost of the school.

Question 2: The only grants paid are through

School Boards to the Association for Retarded Children of British Columbia on behalf of children of school age attending schools operated by local chapters of the Association. The grant is 15% of the net average annual operating cost per pupil enrolled in the public schools, calculated on A.D.A. Right now, it amounts to \$173.43 per year per eligible child.

Question 3:

What are the conditions under which the financial assistance mentioned in the first two questions is given to the parties concerned?

Answer: The conditions under which the financial assistance is given to the Association for the Help of Retarded Children are that the Association submit to the Minister of Education an outline of their proposal to set up a school together with costs, etc., of same. If the Association's proposals are acceptable they are advised to go ahead with the project and payments are made upon audited statements of their expenditures.

Expenditure: This assistance is paid provided that the school board or voluntary group concerned would first work out with the Department plans for the establishment of the class. There



1 is a working arrangement with the Director of  
2 Mental Health branch of the Department of Health  
3 in the establishment of these classes. He sel-  
4 ects the teachers and arranges for their train-  
5 ing in Toronto or Montreal. This Department  
6 shares with the Department of Health the cost  
7 of their training.

8 New Brunswick The pupils must be recommended  
9 for instruction by the Director of a mental health  
10 clinic or some other medical practitioner who  
11 is employed on a full-time basis in the public  
12 service of the Province and is designated for the  
13 purpose by the Minister of Health and Social  
14 Service.

15 Ontario The local association must appoint an  
16 education committee of five members, including  
17 the local inspector of schools, and an annual  
18 return giving various items of information on  
19 the operation of the scholl must be made to the  
20 Department of Education.

21 Manitoba To be included in either a class of  
22 educable retarded or trainable retarded a child  
23 must be certified by a designee of the Minister of  
24 Health and Welfare. In the case of trainable  
25 children in classes of the Association for Retard-  
26 ed Children the child must be six years of age,  
27 ambulatory and toilet trained. The educable are  
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29 pertaining to all pupils apply to them.

30 Saskatchewan The functions of the Department of

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Education are listed in the Special Education Guide of the Department as follows:

1. Provide operational grants for each classroom or school on condition that local school districts assume responsibility for such classrooms or schools, or where a special board operates the facilities and the local school districts contribute funds as outlined under FUNCTIONS OF BOARDS and provided that the board has met all the requirements of the Department of Education.
2. Give guidance to boards or organizations seeking to establish special classes.
3. Provide supervision or see that suitable supervisory arrangements are made.
4. Provide curricula or teaching aids or assist schools in the preparation of such materials, and give other assistance as required or desired.
5. Assist financially with the construction of these special schools.
6. Maintain liaison with the Saskatchewan Association for Retarded Children.
7. Establish desirable requirements for teachers of these classrooms.
8. Define standards of eligibility of children for admission to these classrooms.
9. Assist in determining the needs for these special classes in local areas throughout the province.



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1 10. Assist in case finding.

2 11. Interpret the province-wide program for the  
3 severely mentally retarded children to lay  
4 and professional groups.

5 12. Assist in the program of parent education  
6 as it pertains to these exceptional children.

7 Alberta All schools are subject to inspection  
8 by the Department of Education both as to building  
9 standards and quality of instruction. Having  
10 ascertained that a particular school meets the  
11 requirements of the Department of Education the  
12 payment of grants is authorized.

13 British Columbia The Association for Retarded  
14 Children must form an education committee consisting  
15 of at least three members including the inspector  
16 of schools for the area.

17 The Nova Scotia Association believes that  
18 in this province the grant to local branches of the As-  
19 sociation should be sufficiently large to enable them to  
20 operate the classes without undue financial hardship.  
21 Generally speaking, the Associations are composed of  
22 parents having higher than average expenses in their  
23 homes because of their retarded children, who require  
24 more care and can assist less around the home than  
25 normal children.

26 It is recognized that in some provinces  
27 the average cost of education per pupil and the general  
28 standard of living are higher than they are in Nova Scotia.  
29 The Association therefore recommends that grants be paid  
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The Nova Scotia Association believes that in this province the grant to local branches of the Association should be sufficiently large to enable them to operate the classes without undue financial hardship. Generally speaking, the Associations are composed of parents having higher than average expenses in their homes because of their retarded children, who require more care and can assist less around the home than normal children.

It is recognized that in some provinces the average cost of education per pupil and the general standard of living are higher than they are in Nova Scotia. The Association therefore recommends that grants be paid



1 on either of the following basis: (1) as in New Brunswick,  
2 which is \$1000 for an Association which operates a class  
3 or classes plus \$500 for each teacher plus \$100 for each  
4 pupil; or, alternatively (2) as in British Columbia,  
5 which is 150% of the average cost of educating each pupil.  
6 At present this amounts to \$473.43 in British Columbia.  
7 In Nova Scotia the average cost per pupil was \$200 in  
8 1958, so that it would be approximately \$300 per year or  
9 \$30.00 per month for each pupil.

10 The second way in which assistance might  
11 be given may already be covered in a regulation, but it  
12 is felt to be desirable to have the point clarified.  
13 A board is now permitted to provide conveyance under  
14 the foundation program for pupils who are unable to walk  
15 to school because of a physical handicap, regardless of  
16 how far from the school they live. While it might be  
17 argued that a pupil who is mentally retarded is included  
18 in this regulation, it is recommended that the regulation  
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1 THE CHAIRMAN: Gentlemen, I think perhaps  
2 the fact that not many questions have been asked does not  
3 signify any lack of interest on the part of the Commission,  
4 but I think merely that your presentation has been so  
5 complete and so well done, and it is a submission that  
6 will receive very careful consideration.

7 DR. HOWELL: Thank you very much sir.

8 THE CHAIRMAN: The next submission is from  
9 the Nova Scotia Federation of Labour.

10 SUBMISSION OF THE NOVA SCOTIA FEDERATION OF LABOUR

11 Appearances: J.K. Bell  
12 Sinclair G. Allen  
13 Leo McKay

14 MR. ALLEN: I am sorry, Mr. Chairman, that  
15 it was an oversight on our part in not summarizing the  
16 brief before we presented it to the Commission, but if it  
17 is the wish of you and the Commission we can summarize it  
18 and have it sent to you at a later date. The representa-  
19 tives of the Federation of Labour who are responsible for  
20 drawing this brief up with Mr. Hubert Johnson, the Presi-  
21 dent of the Nova Scotia Federation of Labour and one  
22 other representative of the Nova Scotia Federation of  
23 Labour, and owing to union business they were unable to  
24 be here this morning, and I am sorry, if there were any  
25 questions you wanted to ask they were well-prepared to  
26 answer. I apologize for them on their behalf in not  
27 being here. The Federation is a chartered member of the  
28 Canadian Labour Congress, and the Congress policy is our  
29 policy, and at a later date the Labour Congress will be  
30 presenting a brief to you, and they are familiar with our



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2 answer this morning they will be able to answer at that  
3 date. If it is not the wish of the Commission that this  
4 brief be read through ---

5 THE CHAIRMAN: If you wish. I am going to  
6 leave it to your own good judgment as to how you present  
7 the presentation. If one of your delegation would be  
8 prepared to give a running commentary, or a synopsis of  
9 it, we would be glad to have it.

10 MR. ALLEN: If it is the wish of the  
11 Commission that it be read through I will ask Mr. McKay  
12 if he will read the brief through.

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SUBMISSION

OF

THE NOVA SCOTIA FEDERATION OF LABOUR, C.L.C.

Appearances:

Mr. J. K. Bell,

Sinclair G. Allen,

Leo McKay.

Mr. Chairman and Members of the Commission:

The Nova Scotia Federation of Labour is a Federation of trade unions in this Province which are affiliated to the Canadian Labour Congress. It represents about 45,000 members who, together with their families, represent a considerable proportion of the people of Nova Scotia. The Federation has a long and continuing interest in the question of health care. It welcomes this opportunity to submit its views to you and expressed the hope that your findings will conduce to an expansion of health services and an improvement in the health and general well-being of the people of Canada.

We are pleased to note the breadth of your terms of reference. They provide you as well as us with an opportunity to examine, to appraise and to make recommendations on the kind of program of health care that should be in effect in Canada. While we are naturally concerned with the health needs of the people of this Province in the first instance, we believe that the

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THE NEW

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Province in the first instance, we believe that the





1 question of health services is more than a local matter.  
2 The views which we express and the proposals that we make  
3 below, therefore, are a reflection of a national as well  
4 as a provincial viewpoint.

5 GENERAL REMARKS

6 We wish to emphasize the point that  
7 in our concern with health services, we propose to give  
8 that term the widest possible meaning. We consider such  
9 services to include not only those provided by the medical  
10 practitioner or by the hospital, vital though these are,  
11 but by the other professional and para-professional  
12 personnel and institutions which are to be found in the  
13 field of health care. What we have in mind and what we  
14 will urge before you is not simply a system for the pre-  
15 payment of premiums, leaving the medical status quo  
16 otherwise unchanged, but a health care program in the  
17 fullest sense of that term. We subscribe to the definition  
18 of good health which has been laid down by the World  
19 Health Organization in its Constitution: "a state of  
20 complete physical, mental and social well-being and not  
21 merely the absence of disease or infirmity." We do not  
22 think that the prepayment mechanism by itself can bring  
23 this about.

24 We submit that it can and should be  
25 the right of every citizen, without regard to his social  
26 or economic status, to have access to all those services  
27 and facilities which are or should be available to keep  
28 him in good health as long as possible and to help him  
29 to recover his health when he is struck down by illness  
30 or accident. We believe that the fullest range possible



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### Health Services

We wish to emphasize the point that in our concern with health services, we propose to give that term the widest possible meaning. We consider a service to include not only those provided by the medical practitioner or by the hospital, but also those provided by the other professional and para-professional personnel and institutions which are to be found in the field of health care. What we have in mind and what we will urge before you is not simply a system of the payment of premiums, leaving the medical service otherwise unchanged, but a health care program in the fullest sense of that term. We subscribe to the definition of good health which has been laid down by the World Health Organization in its constitution. It states: "complete physical, mental and social well-being and not merely the absence of disease or infirmity." We do not think that the present mechanism by which we provide this should be changed. We believe that it can and should be the right of every citizen, without regard to his status or economic status, to have access to all those services and facilities which are or should be available to keep him in good health as long as possible and to help him to recover his health when he is struck down by illness or accident. We believe that the present mechanism



1 of health care services should be available to the  
2 citizens of this Province as a matter of right under  
3 appropriate legislation. What we advocate, therefore, is  
4 a system of public health care providing a comprehensive  
5 range of health services under conditions which will  
6 provide health care of the highest quality. We shall  
7 elaborate on this below.

8 EXTENSIVE NEED

9 We do not propose to burden you with  
10 extensive statistical data as to the need for more and  
11 better health services than are available at the present  
12 time. We venture to suggest that the establishment of  
13 your Commission is evidence in itself that a sense of  
14 dissatisfaction exists as to the present situation in that  
15 respect. You undoubtedly have before you the studies  
16 which have emerged from the Canadian Sickness Survey and  
17 you are just as undoubtedly well aware of the findings.  
18 The Survey made it all too clear that there were serious  
19 deficiencies in health care among the Canadian people,  
20 the more so where incomes were low. Dental care was  
21 conspicuous by its absence among low-income groups.  
22 Membership in prepayment plans was similarly limited among  
23 those with limited means. There was in fact, to be found  
24 a very direct relationship between low income and lack  
25 of good health care. This Survey was made ten years ago  
26 and presumably the situation has improved in the interval.  
27 The introduction of hospital insurance is a case in  
28 point. But for the people of Canada, and more particularly  
29 for those who live in the Atlantic Provinces, the situation  
30 is still a long way from ideal. In terms of participation



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1 in prepayment plans alone, the situation is significant  
2 in that there is a lower rate of participation in the  
3 Atlantic Provinces than for Canada as a whole. Data  
4 assembled by the insurance industry indicate that, at the  
5 end of 1957, a little over 25% of the population in the  
6 Atlantic Provinces was covered by prepayment schemes for  
7 surgical benefits and a little over 23% for medical  
8 benefits. This is in contrast to 44% and 37% respective-  
9 ly for Canada as a whole. (Unfortunately no data were  
10 available for Nova Scotia alone.)

11 It is not economics alone that is a  
12 factor of need but the maldistribution and shortage of  
13 medical and other personnel. In the case of dentists,  
14 for example, the population per dentist in Canada has  
15 actually increased from 1946 to 1961: 2,644 in 1946 to  
16 3,037 in 1961 (Source: Canadian Dental Association).  
17 The population per dentist in 1961 by provinces is just as  
18 striking and shows how unequally dentists are distributed  
19 throughout the country:

20  
21 TABLE 1

22 Population per dentist, 1961

<u>Province</u>	<u>Population</u>
Newfoundland	10,929
Prince Edward Island	3,323
Nova Scotia	3,689
New Brunswick	5,000
Quebec	3,679
Ontario	2,423
Manitoba	3,143
Saskatchewan	4,643



in prepayment plans alone, the situation is significant in that there is a lower rate of participation in the Atlantic Provinces than for Canada as a whole. Data assembled by the Insurance Industry indicates that, at the end of 1967, a little over 50% of the population in the Atlantic Provinces was covered by prepayment schemes for surgical benefits and a little over 60% for medical benefits. This is in contrast to 44% and 34% respectively for Canada as a whole. (Unfortunately no data were available for Nova Scotia alone.)

It is not surprising alone that it is a factor of need but the redistribution and savings of medical and other personnel. In the case of dentistry, for example, the population per dentist in Canada has actually increased from 1945 to 1961: 2,644 in 1945 to 2,037 in 1961 (Source: Canadian Dental Association). The population per dentist in 1967 by province is given as striking and shows how unequally dentists are distributed throughout the country.

Table 1

Population per Dentist, 1967

Province	Population
Newfoundland	10,460
Prince Edward Island	8,400
Nova Scotia	3,680
New Brunswick	2,000
Quebec	3,670
Ontario	2,400
Manitoba	3,100
Saskatchewan	2,000





1	Alberta	2,977
2	British Columbia	2,426
3	CANADA	3,037

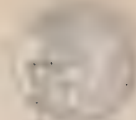
4 - Source: Canadian Dental Association.

5  
6 While Newfoundland stands out in a  
7 way which makes a comparison with the other Provinces  
8 almost impossible, Nova Scotia has a worse ratio of  
9 population per dentist than Prince Edward Island, Quebec,  
10 Ontario, Manitoba, Alberta and British Columbia. The  
11 breakdown of population per dentist within Nova Scotia  
12 would undoubtedly show a distribution just as bad if not  
13 worse as between urban and rural areas.

14 While physicians are in not as short  
15 supply as dentists, their distribution is such that in-  
16 equalities exist as between provinces and the evidence is  
17 all too clear, as you are no doubt aware, that there is  
18 a very heavy concentration of doctors and more particularly  
19 of specialists in the larger cities. The following  
20 table indicates the ratio of population per active civilian  
21 physician in 1959 (population as of June 1, 1959):

22  
23 TABLE 2

24 Province	Population '000	Active Civilain Physicians	Ratio of Active Civilian Physicians to Population
25 Newfoundland	449	205	1/2,190
26 Prince Edward 27 Island	102	74	1/1,378
28 Nova Scotia	716	614	1/1,166
29 New Brunswick	590	409	1/1,442
30 Quebec	4,999	4,724	1/1,058



British Columbia 2,700

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physicians, Manitoba, Alberta and British Columbia. The breakdown of population on new centres which Nova Scotia would undoubtedly show a distribution just as bad if it were as between urban and rural areas.

While physicians are in no better

supply as compared, their distribution is such that in equalities exist between provinces and the ratio is all too clear, as are no doubt aware. That there is a very heavy concentration of doctors and more rural areas

of specialists in the larger cities. The following

table indicates the ratio of population per section

physician in 1950 (population as of June 1, 1950):

TABLE 2

Province	Population 1950	Physicians	Ratio per 1,000
New Brunswick	490	200	1:2,450
Prince Edward Island	100	20	1:5,000
Nova Scotia	710	60	1:11,833
New Brunswick	500	400	1:1,250



1	Ontario	5,952	7,347	1/ 810
2	Manitoba	885	1,004	1/ 881
3	Saskatchewan	902	911	1/ 990
4	Alberta	1,243	1,246	1/ 997
5	British Columbia	1,570	2,046	1/ 767
6	Yukon and N.W.T.	34	20	1/1,700
7	CANADA	17,442	18,600	1/ 938

8 - Source: DBS and Dept. of National Health and Welfare.

9  
10 It may be seen from the foregoing  
11 that Nova Scotia is as a whole better off in regard to the  
12 doctors supply than the rest of the Atlantic Provinces  
13 but is worse off in every province from Quebec west.  
14 Obviously there is still a long way to go before it can  
15 be said that the people of Canada have equal access to  
16 medical care regardless of their geographic location.

17 We could probably adduce other evidence  
18 to substantiate our position that there is a large backlog  
19 of unfilled health care needs. We could elaborate also  
20 on the matter of health care personnel and facilities.  
21 We do not consider it to be necessary, more particularly  
22 on a provincial basis. We consider the question of health  
23 care to be a problem of national concern and to a very  
24 considerable extent for national action, although we do  
25 anticipate and believe that the Province has an important,  
26 even an essential, role to play. You will be receiving  
27 representations from national organizations, including  
28 our parent body, the Canadian Labour Congress, which will  
29 assist you in placing the whole issue in its proper  
30 perspective. You will probably also have made available



3	38	911	902	38	38
4	38	911	902	38	38
5	38	911	902	38	38
6	38	911	902	38	38
7	38	911	902	38	38
8	38	911	902	38	38
9	38	911	902	38	38
10	38	911	902	38	38

- Source: ITS and Dept. of National Health and Welfare.

It may be seen from the foregoing

that Nova Scotia is as a whole better off in regard to the doctors supply than the rest of the Atlantic provinces but is worse off in every province from Quebec west. Obviously there is still a long way to go before it can be said that the people of Canada have equal access to medical care regardless of their geographic location. We could probably adduce many examples to substantiate our position that there is a large number of unfulfilled health care needs. We could elaborate also on the matter of health care personnel and facilities. We do not consider it to be necessary, more particularly on a provincial basis. We consider the question of health care to be a problem of national concern and to a very considerable extent for national action, although we do anticipate and believe that the Province has an important even an essential, role to play. It will be receiving representation from national organizations, including our own body, the Canadian Labour Congress, which will assist you in placing the whole issue in its proper perspective. You will probably also have made inquiries



1 to you studies by your own experts who will have access to  
2 data not readily available to us.

3 PRIVATE PREPAYMENT PLANS

4 It may be submitted to you that the  
5 gap which exists between actual health care services and  
6 those which are needed can be filled simply by making  
7 more universally available membership in the private pre-  
8 payment plans, both of the commercial and non-profit  
9 variety, which exist in large numbers in Nova Scotia and  
10 elsewhere. We do not wish to belittle the role which  
11 these plans have played in the development of health care  
12 programs. They have made a significant contribution in  
13 bringing health care more readily within the reach of  
14 those who became subscribers and made possible the budget-  
15 ing of health care needs, something which is well nigh  
16 impossible to the non-subscriber of ordinary means. But  
17 having said that is not to imply that these plans are  
18 perfection itself or anything closely approaching it.  
19 They are limited by their very nature as instrumentalities  
20 for bringing health care services to the people who need  
21 them. They are not, in our opinion, competent to do the  
22 job that we think needs to be done because of the limita-  
23 tions which are inherent in them. They fail in the  
24 following respects:

25 (1) The private plans are limited  
26 almost entirely to diagnostic and curative services. They  
27 are limited, generally speaking, to the services of the  
28 general practitioner and the specialist. Admittedly these  
29 are extremely important. But to these must be added  
30 preventive and rehabilitative services, as well as the



to you studies by your own experts who will have access to data not readily available to us.

It may be submitted to you that the gap which exists between actual health care services and those which are needed can be filled simply by making more universally available membership in the private payment plans, both of the commercial and non-profit variety, which exist in large numbers in Nova Scotia and elsewhere. We do not wish to belittle the role which these plans have played in the development of health care programs. They have made a significant contribution to bringing health care more readily within the reach of those who became subscribers and made possible the widening of health care needs, something which is well within impossible to the non-subscriber of ordinary means. We have said that it is not to imply that these plans are perfect in itself or anything closely approaching it. They are limited by their very nature as insurance plans for bringing health care services to the people who need them. They are not, in our opinion, competent to do the job that we think needs to be done because of the limitations which are inherent in them. They fall far below

following respects:

- (1) The private plans are limited almost entirely to diagnostic and curative services. They are limited, generally speaking, to the services of the general practitioner and the specialist. Additionally these are extremely important. But to these must be added preventive and rehabilitative services, as well as





1 services which are provided by other than the medical  
2 practitioner. Except to a limited extent, preventive  
3 measures do not fall within the scope of the private plans  
4 and it is difficult for them to accept this function,  
5 partly for reasons of cost, partly that prevention is a  
6 heterogeneous field involving many agencies of government  
7 and diversified application. Furthermore, there are the  
8 services of other professional and quasi-professional  
9 workers which are not normally provided. We have in mind  
10 nurses, dentists, pharmacists, optometrists, medical and  
11 psychiatric social workers, dietitians, practical nurses,  
12 and others. If comprehensiveness of services is to be  
13 sought, as we urge, the private plans are by their very  
14 nature limited and therefore inadequate.

15 (2) The private plans do not make  
16 readily available even the kind of services which are  
17 associated in the public mind with them. They abound in  
18 exclusions and restrictions. Certain medical or surgical  
19 procedures may be excluded entirely; others may be avail-  
20 able only after a waiting period. There are dollar  
21 limitations on certain services. In some other instances,  
22 pre-existing conditions are excluded. An important and  
23 obvious exclusion is dental care.

24 (3) The private plans frequently fail  
25 to cover the complete cost of the services required. This  
26 is especially true of the commercial carriers but it is  
27 true also of those that are sponsored by the medical  
28 profession. The element of insurance, therefore, is  
29 limited and the subscriber is left to carry a portion of  
30 the total cost entirely by himself. If he is tempted to

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usually available even the kind of services which are associated in the public mind with them. They stand in exclusion and restriction. Certain medical or surgical procedures may be excluded entirely; others may be available only after a waiting period. There are dollar limitations on certain services. In some other instances pre-existing conditions are excluded. An important and obvious exclusion is dental care.

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to cover the complete cost of the services rendered. This is especially true of the commercial carriers but it is true also of those that are sponsored by the medical profession. The element of insurance, therefore, is limited and the subscriber is left to carry a portion of the total cost entirely by himself. If he is required to



1 avoid this eventuality by dual coverage, he may find that  
2 he is deprived of his membership in one plan or the other.

3 (4) The private plans do not and  
4 cannot undertake to guarantee the provision of a service  
5 or a facility, nor the proper co-ordination of services.  
6 They merely cover a cost or part of it directly or in-  
7 directly. To the extent that the community provides  
8 hospitals, clinics, laboratories, medical schools and  
9 other facilities, these plans enjoy a subsidy.

10 (5) The private plans do not engage  
11 in research. It is not in their nature to do so. Here  
12 again they benefit by the activities of governments, uni-  
13 versities, foundations and the like.

14 (6) The private plans are not amenable  
15 to public scrutiny and control. Admittedly, the medically-  
16 sponsored plans publish financial statements of their  
17 activities but in the final analysis these plans are  
18 answerable to organized medicine and not to the consumers  
19 on whose behalf they ostensibly exist. So far as the  
20 insurance carriers are concerned, these are private cor-  
21 porations pure and simple. They exist to make a profit  
22 and quite properly do their best to accomplish this.  
23 Their retention rates, policies on experience rating,  
24 loading for special risks or for female lives, these and  
25 other factors that enter into the price of a package of  
26 insurance are subject to internal decisions and are  
27 mitigated only by the fact and to the extent that there  
28 is competition for this kind of business.

29 (7) What is perhaps the most important  
30 objection to the private plans is that they are not







1 concerned with the quality of medical care. They show  
2 little or no interest in seeing to it that their subscribers  
3 obtain treatment at its best. The competence of the  
4 practitioner, the availability of facilities, the effective  
5 co-ordination of medical personnel and facilities to  
6 obtain optimum results, are not inherently their concern.  
7 This is a deficiency of so high an order that if this  
8 were the sole reason for which the private plans were  
9 susceptible to criticism it would suffice to carry the day  
10 against them.

11 In the light of the foregoing, we  
12 submit to you that it is only through a public health care  
13 program that the people of Nova Scotia and of Canada in  
14 general can expect to obtain comprehensive health services  
15 of high quality. What we advocate is a complete program  
16 of health care, including preventive and diagnostic as  
17 well as curative and rehabilitative services, by physicians,  
18 surgeons and other specialists, hospitals and other  
19 agencies. In other words, we propose for every citizen  
20 all the health care he needs in whatever form he needs it,  
21 whenever he needs it, without any economic barrier  
22 between him and health care. We agree with Lord Beveridge  
23 that: "... a comprehensive national health service will  
24 insure that for every citizen there is available whatever  
25 medical treatment he requires, in whatever form he  
26 requires it, domiciliary or institutional, general,  
27 specialist or consultant, and will insure also the  
28 provision of dental, ophthalmic, and surgical appliance,  
29 nursing ... and rehabilitation after accidents."  
30 ("Social Insurance and Allied Services", 1942).

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specialist or consultant, and will insure also the  
provision of dental, ophthalmic, and surgical appliances,

including ... and rehabilitation after accidents."

("Social Insurance and Allied Services", 1945).





In our view, a public health care program should possess the following characteristics:

(1) It should be universal in coverage.

(2) It should be comprehensive in scope.

(3) It should seek to provide health care of the highest quality.

(4) It should be free of any co-insurance, deductibles or other financial deterrents against full use.

(5) It should be financed on a basis which will assure equity in the distribution of the burden of cost.

(6) It should be administered as a branch of government with the understanding that all existing and all new health services are to be effectively co-ordinate.

(7) It should have an appeals procedure.

(8) It should provide for an Advisory Council as part of its administrative structure, such Council being representative of the interests of all those who receive the services and those who provide them.

#### COVERAGE

We advocate universal coverage because that is the only way the people of this Province can be assured that there will be no discrimination against any of them in the matter of entitlement to health services. We do not think that this is a point that needs to be elaborated. We consider it to be a self-evident proposition. Any public health care program which is selective





1 as to membership will inevitably be discriminatory and  
2 there is a strong likelihood that those who will be  
3 discriminated against will be the very ones who will need  
4 health care most. We therefore urge that you endorse the  
5 principle of universality of coverage in any recommenda-  
6 tions that you may make.

7 It is apparent, however, that any  
8 public health care scheme which is introduced will run  
9 into already existing programs, both public and quasi-  
10 public in character. It will therefore be important to  
11 avoid any artificial barriers between one program and  
12 another which may result in some citizens of the Province  
13 falling between them or getting inadequate services  
14 because of fragmentation of the public program or its lack  
15 of effective co-ordination. This is a matter of organi-  
16 zation and we trust that you will give it due considera-  
17 tion.

18 COMPREHENSIVENESS

19 We cannot emphasize too much the view  
20 that a health care program must be in a position to provide  
21 a full range of services if it is to be effective. Again  
22 to quote Lord Beveridge: "From the standpoint of social  
23 security, a health service providing full preventive and  
24 curative treatment of every kind to every citizen without  
25 exceptions, without remuneration limit and without an  
26 economic barrier at any point to delay recourse to it, is  
27 the ideal plan." Comprehensiveness has been defined  
28 in the following terms by an eminent American medical  
29 educationist, Franz Goldman, M.D., Associate Professor of  
30 Medical Care, Emeritus, Harvard School of Public Health:



... membership will inevitably be discriminatory and

... of a select group of people and those who will be

... discriminated against will be the very ones who will need

... health care most. It therefore begs that you endorse the

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... public health care system which is introduced will run

... into already existing programs, both public and private.

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... avoid any artificial barriers between one program and

... another which may result in some citizens of the Province

... being denied from or getting inadequate services

... because of administration of the public program or the lack

... of effective co-ordination. This is a matter of organiza-

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We cannot emphasize too much the view

... that a public care program must be in a position to provide

... a full range of services in order to be effective. Again

... to quote Lord Ruckelshaus: "From the standpoint of social

... policy, a health service providing full preventive and

... curative treatment of every kind to every citizen without

... exception, without discrimination and without an

... economic barrier to any citizen to delay recourse to it is

... the ideal aim." Comprehensive health has been defined

... in the following terms by an eminent American medical

... sociologist, Dr. G. A. Acheson, M.D., Associate Professor of

... Medical Care, Harvard School of Public Health:



"A medical care program can be regarded as comprehensive if the following six conditions are met:

"First, inclusiveness and continuity of service through the stages of health or apparent health, acute illness, convalescence and prolonged illness, whether disabling or not.

"Second, full coverage of all types of personal health services, that is, service by physicians, (in this case physicians to include chiropractors), including specialists as well as generalists, by dentists, including general practitioners and specialists, by pharmacists, by professional and practical nurses, and by all other professional and auxiliary personnel necessary for effective health service.

"Third, full coverage of service at the home of the patient and at office, clinic, general hospital, special hospital, and institution for long term care.

"Fourth, provision of service in the amount required.

"Fifth, provision of service for the period required.

"Sixth, high quality of all services rendered".

-"Rounding Out the Services in Organized Medical Care Programs"; Proceedings of the Group Health Institute of 1959, Group Health Association of America, New York).

It is well worth noting that even in the field of private prepayment plans, there has been a

"A medical care program can be re-

garded as comprehensive if the following six conditions

are met:

1. It covers the stages of health or apparent health,  
2. It covers the stages of illness, convalescence and prolonged illness, whether  
3. It covers the stages of death.

"Second, full coverage of all types

of personal health services, that is, services by physicians,

(in some cases operations to include physiotherapy),

including specialists as well as generalists, by specialists

including general practitioners and specialists by

paramedical, by professional and paraprofessional nurses, and by

all other professional and auxiliary personnel necessary

for effective health services.

"Third, full coverage of services at

the home of the patient and at office, clinic, general

hospital, special hospital, and institution for long term

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Programs; Proceedings of the Group Health Institute of

1960, Group Health Association of America, New York).

It is a well known fact that even in

third of private payment plans, there has been a





1 striving, particularly in the case of those sponsored by  
2 the medical profession, to promote a wide range of  
3 services. It is worth noting also that where a choice  
4 has existed between a relatively restricted plan and a  
5 relatively comprehensive one, the choice has tended to be  
6 in the direction of the latter even though this involved  
7 a higher premium payment.

8 QUALITY OF CARE

9 It is not enough, we believe, for an  
10 arrangement to be made whereby existing health care  
11 services will become available to the people of this  
12 Province. It is important that the services be so arrang-  
13 ed as to provide health care of a high quality. Quality  
14 involves much more than the professional competence of  
15 the practitioner. It includes other factors whose im-  
16 portance cannot be minimized. In a statement on "The  
17 Quality of Medical Care in a National Health Program",  
18 "American Journal of Public Health", July, 1949), the  
19 American Public Health Association defined quality in  
20 terms of quantitative and qualitative adequacy. It stated  
21 first of all that the objective of medical care in a  
22 national health program must include: 1. Promotion of  
23 positive health. (It used at this point the definition  
24 from the Constitution of the World Health Organization  
25 which we have already quoted). 2. Prevention of disease,  
26 disability, and attendant economic insecurity. 3. Cure  
27 or mitigation of disease. 4. Rehabilitation of the  
28 patient. Definitions of quantitative and qualitative  
29 adequacy followed and are given herewith:

30 "Adequate' medical care must meet both





1 quantitative and qualitative standards. Quantitative  
2 adequacy involves both comprehensiveness and balance.  
3 This implies the provision of all services required to  
4 achieve the above named objectives in proper amounts and  
5 with effective timing. Essentials for such quantitative  
6 adequacy include:

7 "1. Participation of medical, dental,  
8 nursing, social service, technical, administrative,  
9 educational, and supporting personnel sufficient to provide  
10 the full range of modern scientific care."

11 "2. Provision of care in home, office,  
12 clinic, health center, general hospital or specialized  
13 institution, according to the best interest of the patient."

14 "3. Provision of drugs, appliances,  
15 laboratory services and other aids."

16 "4. Application of all relevant  
17 services to illness, injury, defect, and maternity - and  
18 to preventive care for the apparently healthy."

19 "5. Education of the public as to the  
20 wisest and most efficient utilization of all available  
21 health services."

22 "The components of qualitative adequacy  
23 may be considered as fivefold:

24 "1. Able, well trained, and efficient-  
25 ly functioning personnel."

26 "2. Facilities and equipment which  
27 meet high technical standards."

28 "3. Health services which encompass  
29 the best knowledge of modern medical science, and which  
30 insure availability and continuity of care."







"4. Adequate financial arrangements, making possible the timely provision of all indicated services, without economic deterrents for patients or practitioners.

"5. Sound administrative organization and operation, designed to promote efficiency and economy of service.

"Each of these factors is, of course, inseparably related to the rest. Effective health service requires competent personnel and facilities of high standard."

The subject has also been dealt with by an eminent international authority on social security, Professor Eveline M. Burns, in her study of "Social Security and Public Policy" (McGraw-Hill, 1956). Dealing with the question of the cost of medical care, she has this to say on its quality:

".... Under a system of public medical care, government cannot evade ultimate responsibility for the quality of medical care in the broadest sense. This involves much more than assuring that the financial and administrative arrangements adopted do not disturb existing patient-doctor relationships or cause a general lowering of the professional standards of the medical personnel, a problem which the national health service has in common with compulsory health insurance systems. It embraces also such questions as whether the system as a whole devotes the proper relative attention to preventive, as contrasted to curative, services; whether adequate provision is made for convalescent or rehabilitative







1 services; whether adequate stimulus is given to research;  
2 whether the mental health services are appropriately  
3 developed; and the like. These are, of course, not  
4 questions that can properly be asked only about a public  
5 service; they are in fact often asked in countries which  
6 rely almost wholly on private enterprise for the provision  
7 of health and medical services. But under a public  
8 program, for the first time the facts are a matter of  
9 public record, and some one authority is held answerable  
10 for failures to reach desired standards for the country  
11 as a whole. It might indeed be said that a much higher  
12 standard is required of government than of private enter-  
13 prise in this respect, and the resulting greatly increased  
14 vulnerability to criticism may be one of the considerations  
15 which have led to some reluctance on the part of govern-  
16 ments to select the alternative of the national health  
17 or medical service".

18                   We have already commented, even  
19 though briefly, on the question of personnel. While it  
20 is to some extent a matter of numbers, it is also a  
21 matter of geographic distribution and balance as between  
22 general practitioners and specialists. This requires  
23 planning. It requires the introduction of the proper  
24 incentives that will induce practitioners to settle  
25 where they are needed. What has been described as  
26 "territorial justice" must inevitably become an objective  
27 of any public health care program. But there is also  
28 the matter of facilities. Quite obviously, if practi-  
29 tioners are to render services of high quality, they will  
30 require the necessary physical resources to supplement







1 their professional training; properly equipped offices,  
2 health centres, laboratories, hospital facilities and the  
3 like. To the extent that this will require new capital  
4 expenditures, the Province will have to face up to this  
5 problem. It has for some years now been a matter of  
6 public policy to make funds available for the improvement  
7 of health facilities and the federal grants-in-aid are  
8 a case in point.

9 At this point we should like to quote  
10 once again from Professor Burns:

11 "Inevitably ... any socialization of  
12 the costs of medical care, however achieved, brings to  
13 the fore the problem of adequacy of facilities and  
14 personnel. Some countries, such as Canada, have decided  
15 that before adopting even a health insurance system steps  
16 must be taken to increase the supply, and improve the  
17 geographical distribution, of medical facilities and  
18 personnel, and public funds are currently being used for  
19 that purpose. Others, such as Great Britain, have first  
20 instituted a free health service and then grappled with  
21 the problem of supplies. Which course is preferable,  
22 assuming the existence of a desire for public action,  
23 would seem to depend upon which one would most speedily  
24 bring supply in relation to demand. A public and a  
25 medical profession that were prepared to accept some  
26 temporary inadequacies but to continue to press for  
27 expanded supplies might find the British sequence prefer-  
28 able to the Canadian. Where, however, there is a hostile  
29 medical profession or a public poorly informed as to the  
30 underlying facts, the lowering of service or even failure







1 of the plan to make good on all kinds of care promised in  
2 the early years until supplies catch up with demand might  
3 endanger the continuation of the service since it would  
4 permit the medical profession to claim that all their  
5 worst fears were realized.

6 "Almost inevitably, too, a government  
7 caught between the pressure of the consumer for more or  
8 higher standards of service and the resistance of the tax-  
9 payer to further levies on his income tends to seek ways  
10 and means of cutting costs, and these efforts often bring  
11 it into conflict with the suppliers of the service. Far  
12 too little is known about the effect of these efforts to  
13 keep costs to a minimum. On the one hand, it has to be  
14 admitted that all professional groups tend to set their  
15 requirements for necessary equipment and facilities by  
16 reference to criteria which emphasize rather the attain-  
17 ment of the highest possible professional standards than  
18 the economic cost of meeting those requirements. They  
19 also tend to resist the allocation to auxiliary personnel  
20 of functions once peculiar to the fully trained practitioner.  
21 On the other hand, unless the lay administrator succeeds  
22 in working closely and constructively with his medical  
23 advisors and unless the profession is willing to co-  
24 operate in keeping costs to a realistic minimum, these  
25 enforced economies may lead to an undesirable and even  
26 an unnecessary lowering of the standards of service."

27 We agree with Professor Burns that it  
28 is essential to undertake a health program at once rather  
29 than wait for needed facilities to be constructed or other-  
30 wise made available. At the same time, we believe that

of the plan to make good on all kinds of care promised in the early years until supplies catch up with demand might endanger the continuation of the service since it would permit the medical profession to claim that all their worst fears were realized.

ought between the pressure of the consumer for more or higher standards of service and the resistance of the payer to further levies on his income tends to seek ways and means of cutting costs, and these efforts often bring it into conflict with the suppliers of the service. Far too little is known about the effect of these efforts to keep costs to a minimum. On the one hand, it has to be admitted that all professional groups tend to set their requirements for necessary equipment and facilities by reference to criteria which emphasize rather the attainment of the highest possible professional standards than the economy, cost of meeting those requirements. They also tend to resist the allocation to auxiliary personnel of functions once peculiar to the fully trained practitioner. On the other hand, unless the lay administrator succeeds in working closely and constructively with his medical advisors and unless the profession is willing to co-operate in keeping costs to a realistic minimum, these enforced economies may lead to an undesirable and even an unnecessary lowering of the standards of service.

is essential to undertake a health program as one rather than wait for needed facilities to be constructed or other what made available. At the same time, we believe that





1 the Government should press forward with the construction  
2 or acquisition of necessary facilities so as to eliminate  
3 the gap between what there is and what there should be as  
4 rapidly as possible. The costs of doing this are a  
5 legitimate part of any public health service program.

6 But even the adequacy of practitioners  
7 and of facilities is not enough in itself. They must be  
8 properly organized and co-ordinated. In this respect we  
9 refer not only to medical practitioners alone but to the  
10 whole range of health care personnel, professional and  
11 non-professional. Inevitably, however, a situation is  
12 directed to the medical practitioner since he is at the  
13 heart of any health care program. It is our view that  
14 advances in medical science and the very sharp increase in  
15 specialization make it imperative for medicine to be  
16 practiced through a team rather than through the more  
17 traditional solo practice. This is not to say that solo  
18 practice is no longer to be tolerated. In some parts  
19 of this Province, especially in the rural areas, the solo  
20 practitioner is likely to continue for a long time. It  
21 does not follow, however, that he should practice in  
22 complete isolation. He should be in a position to  
23 consult with and refer to specialists, possibly through  
24 a regional structure of health care services (in fact, we  
25 think you should pay special attention to the question  
26 of regional organization.)

27 It is not our purpose to decry the  
28 family doctor or to deprecate the role of the general  
29 practitioner. On the contrary, we believe his role should  
30 be magnified. The structure of the scheme should be such,



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It is not our purpose to deny the family doctor or to deprecate the role of the general practitioner. On the contrary, we believe his role should be reaffirmed. The structure of the scheme should be such





1 its medical organizations so arranged, that the general  
2 practitioner, acting as the family doctor, should have  
3 available at all times the knowledge, the skill and the  
4 services of his specialist colleagues, together with the  
5 physical facilities which are related to them. We wish  
6 to add that it is not necessarily the rural practitioner  
7 alone who practices in isolation. The same can be true  
8 of his urban colleague. It is not merely physical  
9 isolation but isolation from the full range of profession-  
10 al resources that can and should be available. It is  
11 teamwork in medicine rather than solo practice which is  
12 now the order of the day. It has been well stated that  
13 "the individual, entrepreneurial form of medical practice,  
14 financed by a graduated, fee-for-service levy on the  
15 individual patient, is an intractable organism not readily  
16 amenable to social planning or professional controls."  
17 ("Organizing Medical Care Programs to Meet Health Needs",  
18 by Avedis Donabedian, M.D., M.P.H. and S. J. Axelrod, M.D.,  
19 M.P.H., September 1961 issue of The Annals of The  
20 American Academy of Political and Social Science.)

21 In a series of lectures on present  
22 day health services in their relation to medical science  
23 and social structures, published under the title "Health  
24 Service, Society, and Medicine" (Oxford University Press,  
25 1960). Dr. Karl Evang, Director General of Health  
26 Services of Norway, has pointed out that: "The G. P. is  
27 the hub of medicine, the personification of medicine -  
28 and I would add, he always was." He adds, however, that:  
29 "Very few professions, if any, with comparably important  
30 tasks are indeed more free from any form of evaluation,



the medical organizations so arranged, that the general practitioner, acting as the family doctor, should have available at all times the knowledge, the skill and the services of his specialist colleagues, together with the physical facilities which are related to them. We wish to add that it is not necessarily the rural practitioner alone who practices in isolation. The same can be true

of his urban colleagues. It is not merely physical isolation from the full range of professional

resources that can and should be avoided. It is a network of medicine rather than solo practice which is now the order of the day. It has been well stated that

"the individual, an experimental form of medical practice

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"any one profession, if any, which completely transcends

tasks are indeed more free from any form of evaluation,



1 assessment or control than that of the self-employed,  
2 individually working G.P." The correction of this is one  
3 reason among many why medical teamwork has developed.  
4 Dr. Evang in this respect states that: "The simple fact  
5 is that the present knowledge of scientific medicine can  
6 often not be administered to the patient without a rather  
7 complicated organization in which there is teamwork in-  
8 volved between specialists of various types. A new and  
9 chaklenging task is to arrange for a proper patient-  
10 doctor relationship in this new context."

11 We wish to emphasize that this is not  
12 an approach taken in the United States or in Norway alone  
13 but is supported in Canada as well. We cite, for example,  
14 the views of Dr. Wendell MacLeod, Dean of Medicine of  
15 the University of Saskatchewan:

16 "Bearing in mind the scientific advance  
17 lying ahead and the socio-economic factors touched on  
18 above it seems logical to expect that the care must be  
19 rendered by a team. At the same time there will be more  
20 need than ever for the potential patient to be related  
21 to one member of the team in a clearly personal way:  
22 someone who will remember him, who will know his strengths  
23 and foibles and whose obligation without question is to  
24 foresee and forestall the breakdowns in health. This  
25 kind of doctor should be specially trained in the skills  
26 of diagnosis because, more than ever before, early  
27 treatment is crucial. He should know when and how to  
28 obtain for his patient the necessary attention of  
29 specialists and he should be familiar with the social  
30 resources of the community which are increasingly helpful.







1 Above all, he must have ample time to talk to the patient,  
2 to get to know him as a person rather than as a 'heart'  
3 or 'a liver', and certainly not as a source of five or  
4 ten dollar bills!"

5 - ("Basic Issues in Hospital and Medical Care  
6 Insurance", a paper delivered to the Study Conference on  
7 National Problems, Queen's University, September 6 to 10,  
8 1960).

9 We have here stressed three principal  
10 factors in the matter of quality of care; adequacy and  
11 proper distribution of personnel, adequacy and proper  
12 organization of facilities, and the organization of  
13 medical care through group practice. As the definition  
14 advanced by the American Public Health Association indicates,  
15 there are other important aspects. Some of these we  
16 have covered elsewhere, such as the question of comprehen-  
17 siveness, for example, in another part of this brief.  
18 Some are self-evident propositions which hardly need  
19 elaboration, as, for example, point 5 of the definition  
20 of quantitative adequacy: education of the public as to  
21 the wisest and most efficient utilization of all available  
22 health services. We propose to deal with other factors  
23 under other headings below.

#### 24 FINANCING THE PROGRAM

25 Without adducing evidence to this  
26 effect, we believe that it is evident that the Province of  
27 Nova Scotia cannot undertake by itself to introduce and  
28 finance the kind of comprehensive health care program that  
29 we advocate. The Province simply does not have the  
30 financial resources to do this. It is inevitable, there-







1 fore, that there should be federal grants-in-aid as a  
2 foundation on which the Province can build. There is  
3 ample precedent for such grants-in-aid as you are well  
4 aware. The Federal Government has provided them for many  
5 years for a variety of purposes. In addition, there is  
6 the recent sliding scale grants-in-aid program for hospital  
7 insurance. We are bound to assume that the poorer  
8 provinces, like those on the east coast, will have to  
9 receive a substantial amount of assistance from the Federal  
10 Government if any worthwhile program is to be introduced  
11 at all. The Federal Government alone has the necessary  
12 tax resources and the ability to effect a redistribution  
13 of its revenues in an equitable way.

14 Assuming federal-grants-in-aid for  
15 a substantial portion of the total cost, our next concern  
16 is how the provincial part of the cost is to be shared by  
17 the population. In our opinion, the most equitable way in  
18 which the burden can be distributed is for the cost to  
19 be covered out of consolidated revenues, assuming that  
20 those are obtained through taxes that reflect ability to  
21 pay. We think this is to be preferred to a system of  
22 premium payments or sales tax, since both of these tend  
23 to be regressive in character.

24 We are also committed to this method  
25 of financing as a first choice by virtue of the fact that  
26 there is no direct or close relationship between the  
27 contribution and the benefit. In the case of unemployment  
28 insurance, for example, there is a direct relationship  
29 between contribution and benefit and it is desirable that  
30 this be so, since the contribution is related to income



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1 and it is desirable that the benefit in turn should be  
2 related to income. In the case of workmen's compensation,  
3 which is somewhat different in structure and principle,  
4 there is also a direct relationship between the claimant's  
5 income and his compensation.

6           These are income-maintenance programs  
7 and this kind of policy makes sense. In the case of  
8 health insurance, however, the matter of contributions  
9 and the services to be provided are related only to the  
10 extent that they must in global terms only bear some  
11 relationship to one another. In other words, it is the  
12 total cost that must inevitably be a governing factor so  
13 far as the government is concerned. But where the  
14 individual subscriber or patient is concerned, any effort  
15 to create a direct relationship between his contribution  
16 and the volume of services he requires must inevitably  
17 lead in many cases to inadequate care. We have already  
18 stated the principle that we believe should be established  
19 in this respect: that the patient should be able to get  
20 all the medical care he requires based on health need  
21 without any economic obstacle standing in the way.

22 Accordingly, financing through consolidated revenue  
23 presents a method of financing which does not create any  
24 direct and obvious obstacle.

25           We would be flying in the face of  
26 reality if we did not recognize the fact that the Province  
27 at present finances its hospital insurance program through  
28 a sales tax. So far as the sales tax is concerned, it  
29 is obviously a regressive form of taxation with a tendency  
30 to bear down most on those least able to pay. Presumably

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1 its regressive character can be mitigated to some extent  
2 at least by the locus of its imposition. The luxury tax  
3 is a case in point, where a relatively high tax is  
4 imposed on those goods which by their nature cannot be  
5 deemed to be necessities or even reasonable conveniences.

6 If a sales tax is sufficiently selec-  
7 tive, therefore, it can presumably be less objectionalbe  
8 than one which is imposed in a much more wholesale fashion.  
9 But, however regarded, the sales tax must bear the odium  
10 of being a tax with a built-in inequity.

#### 11 OPPOSITION TO DETERRENTS & CO-INSURANCE

12 We are strongly opposed to the  
13 inclusion of any deterrent or co-insurance charges as  
14 part of the financing method of any proposed health in-  
15 surance program.

16 Our objections to these factors in  
17 financing are twofold. We object to them in the first  
18 instance because they place barriers between the person  
19 who requires medical care and the services that are re-  
20 quired. We object to them as well on the grounds that  
21 they are regressive in character and place the burden for  
22 health care unfairly on those who are using it, rather  
23 than on the population as a whole on the basis of ability  
24 to pay, at the same time eliminating that pooling of risk  
25 which is characteristic of insurance.

26 The purpose of a deterrent charge is  
27 obvious from its name. It is to discourage the would-be  
28 patient from making frivolous or capricious demands for  
29 services. It is manifestly unfair in this regard at least,  
30 that what is a deterrent for one person is not for another.



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1 Accordingly, the relatively well-to-do can indulge their  
2 whims while those financially less well off are not able  
3 to. The deterrent charge thus tends to concentrate on  
4 lower income groups. Yet it is those very low income  
5 groups which stand most in need of medical care as the  
6 Canadian Sickness Survey has indicated all too clearly.

7                   There is another and still more ob-  
8 jectionable feature to such charges. They have the result  
9 of leaving to the subscriber rather than to the doctor  
10 the decision of deciding whether or not medical care is  
11 required since it is the would-be patient who will make  
12 the decision in the first place as to whether or not the  
13 doctor should be called. This to our way of thinking is  
14 hardly good medicine. We have yet to see any satisfactory  
15 definition as to what represents a flimsy pretext for  
16 calling upon medical aid. Quite clearly this is bound to  
17 be a subjective matter. Quite clearly also it is liable  
18 to result in the postponement of needed care because of  
19 mis-judgment and apprehension about cost, with the  
20 inevitable result in some instances that what were  
21 originally minor illnesses have reached much more serious  
22 proportions by the time the doctor is finally called in.

23                   Insofar as co-insurance is concerned,  
24 the term "co-insurance" is simply a euphemism to disguise  
25 the fact that the person paying for the service has to  
26 cover a part of it entirely on his own. Contrary to the  
27 term itself, there is no joint participation in that part  
28 of the total cost. Here again, therefore, the burden is  
29 placed unfairly on the sick whereas it should be spread  
30 over the population. The arguments for co-insurance in



Accordingly, the relatively well-to-do can indulge their whims while those financially less well off are not able to. The deterrent charge thus tends to concentrate on lower income groups. Yet it is these very low income groups which stand most in need of medical care as the Canadian sickness survey has indicated all too clearly. There is another and still more on-

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definition as to what represents a "fair" pretext for calling upon medical aid. Quite clearly this is bound to be a subjective matter. Quite clearly also it is liable to result in the postponement of needed care because of mis-judgment and speculation about cost. With this inevitable result in some instances that what were originally minor illnesses have reached much more serious proportions by the time the doctor is finally called in. Insurance as co-insurance is concerned.

The term "co-insurance" is simply a euphemism to disguise the fact that the person paying for the service has to cover a part of it entirely on his own. Contrary to the term itself, there is no joint participation in that part of the total cost. Here again, therefore, the burden is placed unfairly on the sick whereas it should be spread over the population. The arguments for co-insurance in



1 the private industry are that the subscriber should be  
2 able to bear the cost of small incidents himself and an  
3 analogy is drawn to car insurance. Unfortunately, however,  
4 while a car owner may choose to disregard a bent fender,  
5 he may not feel the same way about a broken rib. The  
6 analogy is a false one.

7 Co-insurance is simply a device  
8 developed by the private insurance industry to reduce its  
9 cost on claims and to offer a premium rate which can more  
10 readily be sold. This policy was introduced also into  
11 the same of prepayment plans by the insurance companies;  
12 it is a standard feature of major medical insurance, for  
13 example, and for the same reasons. The insurance industry  
14 exists to make a profit which is perfectly proper. It is  
15 bound to take measures which will maximize its profit and  
16 reduce its potential losses. But the incentives of a  
17 public health insurance program are entirely different.  
18 Profit is not a consideration and the emphasis is on  
19 good health, its maintenance or re-establishment.  
20 Accordingly, to the extent that co-insurance is an obstacle  
21 to that goal, it is undesirable as well as being un-  
22 equitable.

#### 23 REMUNERATION OF PHYSICIANS

24 With respect to a number of the  
25 professions and quasi-professions that exist in the health  
26 care field, the problem of the method of remuneration is  
27 not a matter of any significance. So far as nurses,  
28 dietitians, physiotherapists, medical social workers, and  
29 other classes of professional and technical employees are  
30 concerned, these have habitually been paid on a salary

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1 basis and this system of payment should be continued.  
2 There is no reason for changing it. With regard to the  
3 physician, however, there is a matter of prime importance  
4 involved. By and large, the position of the medical  
5 profession is that remuneration of doctors should be on  
6 the basis of fee-for-service. This position overlooks  
7 the fact that a considerable proportion of doctors in  
8 Canada are on salary, but in the case of the non-salaried  
9 practitioner, fee-for-service is in fact the major if not  
10 the exclusive method of payment. We submit that under a  
11 public health care program the fee-for-service method is  
12 not desirable and there should be substituted for it a  
13 salaried method of payment.

14                   The fee-for-service method of payment  
15 is objectionable on a number of grounds. To laymen,  
16 looking at it from an administrative point of view if from  
17 no other, it appears to be unnecessarily involved and  
18 cumbersome, therefore costly. By its very nature it  
19 must require a considerable amount of record-keeping by  
20 the doctor and by the government agency. Each medical  
21 treatment must be recorded for accounting purposes and  
22 forms must be filled out by or on behalf of the doctor  
23 for submission to the government agency in order to obtain  
24 payment. If the system involves billing by the doctor to  
25 the patient and the reimbursement to the patient by the  
26 government agency, the administrative complications are  
27 in no way mitigated. Extensive records must still be kept.  
28 Even in a province like Nova Scotia with a relatively  
29 small population, the number of individual items of care  
30 for which payment would have to be made could conceivably

basic and this system of payment should be continued. There is no reason for changing it. With regard to the physician, however, there is a matter of prime importance involved. By and large, the position of the medical profession is that remuneration of doctors should be on the basis of fee-for-service. This position overlooks the fact that a considerable proportion of doctors in Canada are on salary, but in the case of the non-salaried practitioner, fee-for-service is in fact the major if not the exclusive method of payment. We submit that under a public health care program the fee-for-service method is not desirable and there should be associated for it a salaried method of payment.

The fee-for-service method of payment is objectionable on a number of grounds. To begin with, looking at it from an administrative point of view it is, as other, it appears to be unnecessarily involved and cumbersome, therefore costly. By its very nature it must require a considerable amount of record-keeping by the doctor and by the government agency. Each medical treatment must be recorded for accounting purposes and forms must be filled out by or on behalf of the doctor for submission to the government agency in order to obtain payment. If the system involves filling by the doctor to the patient and the return of the patient by the government agency, the administrative complications are in no way mitigated. Extensive records must still be kept. Even in a province like Nova Scotia with a relatively small population, the number of individual items of care for which payment would have to be made could conceivably





1 run into the millions per annum. If bureaucracy and  
2 bureaucratic procedures are to be feared, here are their  
3 basic elements. When added to this enormous task of  
4 record-keeping is the determination and establishment of  
5 fee schedules, the problem becomes even greater. The  
6 business of making the schedule, its refinement, its  
7 adequacy, the recognition of special circumstances, must  
8 inevitably result either in complex and protracted nego-  
9 tiations or, what is perhaps worse, in a situation where  
10 the consumer of medical services is left, as he is now  
11 under this system, to deal as best he may with his doctor.  
12 The economic obstacle would still remain.

13                   Protagonists of the fee-for-service  
14 method of payment will undoubtedly point to the fact that  
15 this method is in effect in Australia, New Zealand and  
16 other countries. As a statement of fact, this is incon-  
17 trovertible. But simply to state it as a fact is not to  
18 justify it. It seems quite clear that if in Australia  
19 and New Zealand, to cite examples, the fee-for-service  
20 method is in effect, it was not introduced because the  
21 governments of these countries thought that this was the  
22 most desirable method of remuneration. It seems clear  
23 from the record that the governments reluctantly accepted  
24 this system in the face of the intransigence of an  
25 entrenched medical profession. (See, for example,  
26 "Medical Services in New Zealand" by Hugh McLean, M.D.,  
27 F.A.C.S. and Dean E. McHenry, Ph.D., in the Millbank  
28 Memorial Fund Quarterly, April, 1948 issue; and "The  
29 National Health Service in Australia" by Ronald R. Winton,  
30 M.B., B.S., in the British Medical Journal, issue of







1 July 5, 1958.) We make this point to emphasize the fact  
2 that the fee-for-service system has not won its way by,  
3 popular acclaim but was granted as a concession to the  
4 doctors since otherwise the medical profession would not  
5 have given the co-operation necessary to make the health  
6 insurance programs effective. There is no doubt in our  
7 minds but that the attraction which fee-for-service has  
8 for the medical profession is based primarily on economic  
9 motives.

10 Fundamentally, the fee-for-service or  
11 piece work system is objectionable because it tends to  
12 undermine quality of care, thriving as it does on quantity  
13 rather than on quality, and promoting wasteful, even  
14 dangerous, competition, instead of collaboration in medical  
15 care. It is significant that this viewpoint is not  
16 merely the reaction of laymen but is a viewpoint held by  
17 eminent medical men. Thus Dr. James Howard Means, a  
18 former President of the American College of Physicians  
19 has this to say ("Doctors, People and Government", 1953):

20 "Doctors by and large tend to work too  
21 long and too hard either for their own good or for that  
22 of their patients. The competitive nature of their work  
23 is largely responsible for this situation...

24 "The tragic thing is that this situa-  
25 tion is remediable if the doctors could be made to see it.  
26 The fee-for-service method of payment, in my opinion, is  
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28 practice, the more fees he collects the better off the  
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1 for him nor the patient....

2 "It has been argued that the salaried  
3 doctor does less good work than he who is on the fee-for-  
4 service basis. I submit that there is abundant evidence  
5 to the contrary. In government service, in teaching  
6 clinics, and in such places as the Mayo Clinic, where all  
7 doctors are on fixed salaries, medicine of the highest  
8 quality can be, and often is, done.

9 "... The chief objections to the  
10 uncontrolled fee-for-service system, as I see it, are that  
11 it may on the one hand tempt the doctor to call upon  
12 or summon the patient to his office oftener than is  
13 necessary and, on the other, that it may keep the patient  
14 away from the doctor when he really should go. It is  
15 difficult to induce a patient to go to the doctor for  
16 periodic check-ups when he is feeling well, under a fee-  
17 for-service system. It is the easiest thing in the world  
18 to get him to do so when he is entitled to it under a  
19 capitation or prepayment plan of some sort."

20 In a review of the New Zealand scheme,  
21 the following is a conclusion drawn by the author ("The  
22 Social Security Medical Services in New Zealand" by J.P.S.  
23 Jamieson, C.B.E., M.D., F.R.A.C.S., in British Medical  
24 Journal, July 5, 1958):

25 "All is not beyond reproach. There is  
26 not the same amount of personal attention by doctors. It  
27 is more profitable to 'see' six of ten patients than to  
28 spend the time in the examination and diagnosis of one,  
29 or to undertake minor surgery. So there is undue reference  
30 of patients to hospital for things the doctor should do

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doctor does less good work than he who is on the fee-for-

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1 for himself. Quantity rather than quality pays better.  
2 There is waste of drugs. In some cases there is a tend-  
3 ency to exploit the Fund by over-attendance. Specialism  
4 ~~grows apace~~, and the tendency is to specialize immediately,  
5 without the invaluable training of a period of general  
6 practice. This change from the doctor of former days,  
7 comprehensive in his scope, to the modern who, though  
8 the facilities for diagnosis and treatment are so much  
9 better, refers more and more to hospitals and specialists,  
10 is leading to a change in the popular regard of 'the  
11 doctor.' He is losing his former prestige. There remains  
12 also the tendency, common to all governments, to take  
13 more and more control of the individual."

14 Another writer on the New Zealand  
15 scheme has this to say "The New Zealand Medical Service -  
16 An Appraisal" by Douglas Robb, C.M.G., M.D., F.R.C.S.  
17 (Eng.), in Canadian Medical Association Journal, February  
18 20, 1960):

19 "The refund system carries a propor-  
20 tion of bad debts for the doctor: the patient has to use  
21 his receipted bill as a claim, and it is often hard for  
22 the patient to find the cash to pay the full amount, even  
23 if he knows he is to get a refund. It is rightly said  
24 that there is little wrong with the refund system so long  
25 as it is not compulsory.

26 "The schedule system is under criticism  
27 by some doctors as being uncondusive to the best patient-  
28 doctor relations, and in laying undue emphasis on its  
29 financial aspects. It also does nothing to foster the  
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1 government's (and the taxpayer's) viewpoint the system  
2 is a 'bottomless pit' with no check on the total cost.  
3 The doctor can abuse it by over-visiting and over-count-  
4 ing attentions made. The inescapable tendency to pump  
5 up small practices has been demonstrated graphically by  
6 Thompson (1959). Though the population per doctor  
7 throughout the country fell from 1477 in 1952 to 1289 in  
8 1957, the average payment to the doctor using the schedule  
9 system rose from L.2173 to L.2448 (\$5084 to \$6854). In  
10 the case of doctors using the refund system there was no  
11 change in the average payment."

12 It may be seen from the foregoing  
13 that the fee-for-service system of remuneration for  
14 doctors is open to a number of serious objections. It  
15 increases the load of paper work for both the doctor and  
16 the administrative agency. It leads to competitive rather  
17 than co-operative effort among doctors. It may create  
18 economic obstacles between the patient and the doctor.  
19 It results in abuses such as the rendering of unnecessary  
20 services, thereby reducing professional standards and  
21 adversely affecting medical ethics. We believe these are  
22 sufficiently good reasons to reject the fee-for-service  
23 system of payment out of hand as the method of paying  
24 general practitioners in Nova Scotia under any provincial  
25 health insurance program.

26 Before turning to other methods of  
27 remuneration and indicating our own preference, we wish to  
28 state in more general terms our views as to remuneration  
29 of doctors. Regardless of the method of remuneration, we  
30 believe that doctors should be well paid both relatively

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of doctors. Regardless of the method of remuneration, we

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1 and absolutely. Their income should be sufficient for  
2 them to enjoy a high standard of living in the accepted  
3 sense of that term. Remuneration should reflect the  
4 status of the doctor as a member of a highly regarded  
5 profession and his indispensable role in the community.  
6 It should be commensurate with his long period of train-  
7 ing, his experience, the time and effort spent on his  
8 work, and the occupational hazards of his practice. We  
9 do not believe for a moment that the doctors who practice  
10 medicine in this Province should enrich themselves at the  
11 expense of the community under a system of public health  
12 insurance but neither do we subscribe to the view that  
13 there should be a levelling down merely because of such  
14 a program except to the extent that it may be necessary  
15 to even out gross inequalities.

16 We believe further that the doctor  
17 should have a right to see his remuneration determined  
18 through negotiations between his professional organization  
19 on the one hand and the Government on the other. Orderly  
20 procedures should be provided for this purpose and they  
21 should include some method for the settlement of any  
22 disputes which may arise. Generally speaking, we agree  
23 with Dr. Franz Goldmann that "In evaluating and comparing  
24 the financial arrangements, attention must be given to  
25 the rate as well as the form of payment, the effect on  
26 the type, quality, and quantity of service, as well as  
27 the time and total professional income of the physician,  
28 and to the administrative implications" (paper on "Methods  
29 of Payment for Physicians Services in Medical Care Programs",  
30 presented before the Medical Care Section of the



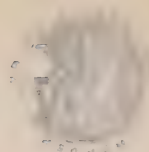


American Public Health Association, San Francisco, October 31, 1951). Perhaps doctors will not be as concerned as workers are to enjoy the right to negotiate over terms of remuneration. If not that is their right. But if they wish to engage in what we would normally call collective bargaining, we believe they are entitled to do so and to have their professional organization recognized as their bargaining agent.

Turning once again to the method of remuneration, we propose that you give serious consideration to a system of payment by salary. The salary method has a number of advantages. Administratively, it is simple, even where there is a range of salaries or salaries plus supplementations, as compared to fee-for-service or even the capitation method of remuneration. In addition, it is familiar even to physicians since about one-quarter or more of all active civilian physicians in Canada are paid on a salary basis. In addition, the salary system has this obvious advantage for the doctor that it assures him a guaranteed income which is absent under the fee-for-service system. We would remark here in passing that reference to salary does not preclude, in our opinion, the addition to any salary of such indirect or deferred payments as a pension, paid sick leave, group life insurance, holidays with pay, time off to attend conventions or to take refresher courses, and other fringe benefits.

The criteria that we are using in connection with remuneration include one which requires that it should encourage professional incentives in





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1 furnishing services and discourage financial incentives.  
2 It is in this respect that we consider the salary method  
3 of payment most important. We have already shown that the  
4 fee-for-service method provides the wrong kind of in-  
5 centives. It breeds competition. It may encourage over-  
6 utilization and even procedures for which the practitioner  
7 is not properly qualified. We have argued and have  
8 adduced evidence to the effect that a piece work system  
9 of payment is not conducive to the highest quality of  
10 medical care that is available. A salary system would,  
11 on the contrary, provide the necessary incentives.  
12 Assured of his income, the doctor would be able to con-  
13 centrate on his practice. The number or turnover of  
14 patients, while it might be a cause for concern in itself,  
15 would not materially affect his economic security. Freed  
16 from the necessity of pursuing fees and from the tempta-  
17 tion of adding patient to patient or service to service,  
18 the doctor could devote his whole energy to professional  
19 work and to professional collaboration with his colleagues.  
20 He would keep abreast of scientific progress without  
21 sacrificing income; he could concentrate on high standards  
22 of service, again without fear of loss of income. He  
23 would furthermore be freed from the paper work inevitably  
24 attached to fee-for-service.

25 We have been influenced, as you are  
26 aware, by the need for group practice of medicine. There  
27 can and should be a close relationship between a salary  
28 system of payment and a group method of practice. In  
29 this respect we wish to cite once more from Dr. Means:

30 " ... First, I believe that payment



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1 for medical care on a fee-for-service-as-rendered basis  
2 is outmoded. It is not conclusive to the best care of  
3 patients in present-day society. Instead I believe that  
4 prepayment plans, which afford benefits directly in the  
5 forms of comprehensive service, are today the method of  
6 choice. Secondly, I think that doctors should preferably  
7 be paid by salary - adequate salary - or by salary plus  
8 a share of the earnings in the case of medical groups.  
9 Thirdly, I am convinced that the time has come, because of  
10 the complexities of modern diagnosis and treatment, when  
11 medicine should be practiced usually by groups of doctors  
12 rather than by individual practitioners. Professional  
13 groups, of course, will be of many varieties. The type  
14 suitable for one community may be unsuitable for another.  
15 'Organization for medical care' is the generic term I  
16 would apply to all types of professional teams or groups.  
17 Without such organization, in one form or another, full  
18 advantage of our rapidly expanding scientific knowledge  
19 cannot be taken for the benefit of patients."

20                               There may be required some modification  
21 of or augmentation to the salary system in order to assure  
22 equity as between general practitioners. It may well be  
23 that salaries should be supplemented by some degree of  
24 capitation in order to balance out to some extent differ-  
25 ences in potential volume of work. Assuming a basic  
26 salary or a basic progression of salaries across the  
27 board, capitation may conceivably provide recognition of  
28 the fact that in some areas the number of patients per  
29 practitioner is higher than average. Thus, while a rural  
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1 may have relatively few patients because he is in an  
2 isolated area, by the same token the practitioner in a  
3 more densely populated area and having considerably more  
4 patients should have a capitation supplement, in recogni-  
5 tion of this fact. This proposal injects a complicating  
6 factor into a relatively simple procedure but this may  
7 be unavavoidable. In any case, administrative ease,  
8 however desirable, should not be permitted to obtain  
9 priority over equity in treatment. So long as such  
10 augmentation of income is marginal rather than the main  
11 source, consideration might even be given to a limited  
12 degree of payment on a fee-for-service basis. Just to  
13 what extent we do not feel prepared to say except that  
14 it should be a relatively small proportion of total income.  
15 Such payment would be applicable, we would assume, where  
16 there is a large volume of work involved or it might be  
17 injected simply in order to encourage the submission of  
18 the kind of detailed data that is essential for important  
19 statistical compilations. But here as in the case of  
20 capitation, we wish to stress the view that the non-  
21 salary payment should be a supplement and a small one at  
22 that.

23 Certain supplementation may be re-  
24 quired regardless of the principal form of payment. It  
25 may be necessary to provide compensation for a practice  
26 that is relatively isolated or hazardous. It may also be  
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 29 preference to those where the ratio of doctors to  
 30 population is more adequate. A mileage allowance might



1 have to be considered for rural practitioners. Those are  
2 not matters of principle. They are practical problems  
3 that any administrative agency will have to consider and  
4 it is better that considerations be given beforehand than  
5 after grievances occur.

6 So far as the remuneration of  
7 specialists is concerned, other considerations may enter.  
8 The salary system could well be applied to specialists as  
9 to general practitioners under certain circumstances. It  
10 would be practicable as it already is where the specialty  
11 is hospital-centred. It would also be applicable where  
12 the specialties are co-ordinated under a group practice  
13 arrangement. The British practice has been to attach the  
14 specialist to the hospital and to pay him a salary. It  
15 has apparently worked out well judging from the Pilkington  
16 Report.

17 Another kind of arrangement may have  
18 to be made where the specialist engages in solo private  
19 practice and wishes to continue to do so. Under such  
20 circumstances, it may be necessary to enter into an  
21 arrangement whereby he will render services under the  
22 public program during part of his working hours. In this  
23 instance, it would be desirable to pay him on a sessional  
24 basis, that is, on a flat fee basis depending on the  
25 number of hours, days or parts of days during which he  
26 is providing services to patients covered by the public  
27 scheme. This arrangement has worked well in the federal  
28 Department of Veterans Affairs. It goes without saying  
29 that if the general practitioner is to be adequately paid,  
30 with his compensation reflecting responsibility and

have to be considered for mutual practitioners. Those are not matters of principle. They are practical problems that any administrative agency will have to consider and it is better that consideration be given beforehand than after grievances occur.

So far as the remuneration of specialists is concerned, other considerations may enter. The salary system could well be applied to specialists as would be practicable as it already is where the specialist is hospital-employed. It would also be applicable where the specialists are co-ordinated under a group practice arrangement. The British practice has been to award the specialist to the hospital and to pay him a salary. It has apparently worked out well judging from the R.M.A.s.

Another kind of arrangement may have to be made where the specialist engages in solo private practice and wishes to continue to do so. Under such circumstances, it may be necessary to enter into an arrangement whereby he will render services under the public program during part of his working hours. In this instance, it would be desirable to pay him on a seasonal basis, that is, on a flat fee basis depending on the number of hours, days or parts of days during which he is providing services to patients covered by the public scheme. This arrangement has worked well in the Federal Department of Veterans Affairs. It goes without saying that the general practitioner is to be adequately paid with his compensation reflecting responsibility and





1 experience, the same must be true of the specialist. The  
2 system of remuneration must recognize differentials  
3 between the generalist and the specialist, with a hierarchy  
4 of scales of payment which will take into account such  
5 factors as specialist certifications, responsibility, and  
6 so on.

7 Dentists represent a special problem  
8 in view of their relative scarcity and the fact that such  
9 scarcity is bound to continue for some time to come. A  
10 method of remuneration must be worked out which will not  
11 undermine the preventive services which are an essential  
12 of dental hygiene. A fee-for-service basis of payment is  
13 likely to result in concentration on the costlier proce-  
14 dures and to draw dentists away from preventive programs.  
15 It may also result in an excessive degree of payment to  
16 dentists. We submit that the salary system should be  
17 considered as a basic means of remuneration, subject to  
18 supplementation by some other means. In framing the means  
19 and degree of remuneration, consideration should be given  
20 to the need for attracting more dentists into the Province  
21 and for a better distribution.

## 22 23 ADMINISTRATION

24 Turning specifically to administrative  
25 methods, there are various ways in which a public health  
26 program can be administered. It can be done through the  
27 Department of Public Health. It can be administered  
28 through a Board or a Commission consisting of full-time  
29 members, or by a part-time or honorary Board with main  
30 emphasis on administration being placed in the hands of





1 professional administrators, the Board being concerned  
2 largely with supervision and policy. As in the case of  
3 the federal Board of Broadcast Governors, the administra-  
4 tion can be placed in the hands of a mixed group, some  
5 full-time and some part-time.

6 None of the foregoing administrative  
7 structures is perfect in itself. Each has its own strengths  
8 and weaknesses. Our concern has been to determine what  
9 kind of structure would most likely provide administrative  
10 efficiency in the fullest sense of the term. We have in  
11 mind not only economical administration so far as paper  
12 work is concerned but the kind of efficiency that will  
13 make a comprehensive health care program truly effective.  
14 This would require efficient communication with doctors  
15 and other practitioners, professional and otherwise, as  
16 well as with their professional trade associations, with  
17 other departments and agencies of government and with  
18 health organizations, and with the public in its capacity  
19 both as beneficiary and taxpayer. Above and beyond all  
20 this, the administration would have to co-ordinate and  
21 rationalize the variety of services that a comprehensive  
22 health care program would involve and which we have already  
23 described to you.

24 We have come to the conclusion that  
25 the best way for such a program to be administered would  
26 be to place it under the Department of Public Health. We  
27 are influenced in this judgment by the fact that there  
28 would inevitably have to be organic unity between other  
29 provincial health programs and the type of program that  
30 we propose here. It will be better to add and co-ordinate





professional administrators, the Board being concerned largely with supervision and policy. As in the case of the Federal Board of Industrial Governance, the administration can be placed in the hands of a mixed group, some

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kind of structure would most likely provide administrative efficiency in the limited areas of the firm. We have in mind not only economical administration so far as possible work is concerned but the kind of efficiency that will

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other departments and agencies of government and with health organizations, and with the public in its capacity both as beneficiary and taxpayer. Above and beyond all

this the administration would have to co-ordinate and rationalize the variety of services that a comprehensive health care program would involve and which we have already discussed in detail.

We have come to the conclusion that

one best way for such a program to be administered would be to place it under the Department of Public Health. We are convinced in our judgment by the fact that there would inevitably have to be organic unity between other health and health programs and the type of program that we propose here. It will be better to add and co-ordinate



1 existing programs than to create a new provincial agency.  
2 Furthermore, integration at the provincial level would  
3 mean that it would be possible to achieve regionalized  
4 administration and co-ordination.

5 It is sometimes stated that one of  
6 the disadvantages of government administration is its  
7 undue rigidity. It is claimed that there is little or no  
8 room for discretion. We would argue that this kind of  
9 criticism can be made just as validly about a Board, a  
10 Commission or even about the large modern corporation.  
11 Whether an administrative agency is rigid or flexible,  
12 and whether its servants may or may not exercise discretion,  
13 are determined by the rules under which the agency  
14 operates and by the calibre of the people appointed to  
15 operate it. Flexibility will have to be written into any  
16 provincial program. How much there should be will be  
17 determined by the scope of the scheme itself. We contem-  
18 plate sufficient centralization of control to accomplish  
19 the following: (1) the establishment of province-wide  
20 standards of services to be provided; (2) the co-  
21 ordination of such services; (3) evaluation, research  
22 and planning, of the medical care, administrative and  
23 financial aspects of the program; (4) liaison with  
24 professional and other associations of practitioners in  
25 the medical field; (5) recruitment of personnel; (6)  
26 establishment of standards of remuneration.

27 We have already made reference to the  
28 matter of regionalization of the public health care  
29 service. As we have stated above, we believe there is  
30 merit in some degree of decentralization and local autonomy,







1 subject to the overall rider that no health region should  
2 be allowed to provide services of an inferior order in the  
3 name of local autonomy. Bearing this in mind, we believe  
4 that the regions can serve a very useful purpose in:  
5 (1) co-ordinating various services within the region;  
6 (2) assisting in the development of new services as the  
7 need for them arises or as facilities become available;  
8 (3) assisting in the determination of and planning for  
9 needs; and so on. Health regions could also play a useful  
10 part in keeping in close touch with the users of the  
11 services and with those who provide the services, something  
12 which is more difficult for the central administration.  
13 Generally speaking, health regions can be a very great  
14 help to the central administration in translating the  
15 provincial program into local terms based on local needs,  
16 always subject to the stipulation that the objective must  
17 be to improve on the status quo rather than to maintain it.

18 We recognize the fact that the problem  
19 of administration is far more complex than we have  
20 suggested above. It is a matter calling for the greatest  
21 technical skill and competence. We have confined ourselves  
22 to a broad statement since we hesitate to enter into  
23 technical detail of this sort. Our main purpose in this  
24 brief has been to set out in broad terms the kind of  
25 program we wish to see for the people of Nova Scotia.

#### 26 27 APPEALS PROCEDURE

28 We submit that any public program such  
29 as we advocate should possess an appeals procedure for  
30 those with grievances arising out of the operation of the







1 program itself. There must be safeguards against arbitr-  
2 ary rulings as well as against errors of commission or  
3 omission in its administration. During its formative  
4 years especially, the appeals procedure would be an  
5 important test of the scheme's effectiveness and subse-  
6 quently an index of its efficient operation.

7                               There are a variety of areas in which  
8 such an appeals procedure could operate: the determination  
9 of coverage in or exclusion from the plan; the relation-  
10 ship between a practitioner and the administration with  
11 respect to such matters as remuneration, supplementations,  
12 location, etc; the relationship between a group practice  
13 or any other agency and the administration; the entitle-  
14 ment to benefit; and so on. These and presumably other  
15 matters may be a source of grievance and machinery should  
16 exist for the right of appeal, the right to an impartial  
17 hearing and to redress if the grievance is well founded.

18                           It is noteworthy that the draft Bill  
19 for a Health Insurance Act contained in the Heagerty  
20 Report included a provision for the determination of  
21 questions (section 47 of the draft Bill, Report of the  
22 Advisory Committee on Health Insurance, 1943). We do not  
23 endorse the specific provision in that draft. We merely  
24 draw the fact to your attention.

25                           Since we have envisaged a program  
26 decentralized to a degree through regionalization, we  
27 believe the appeals procedure should also allow for  
28 appeals to be made to local boards rather than directly  
29 to a central authority. We favor local boards represen-  
30 tative in character and including lay as well as professional





program itself. There must be safeguards against applying any rulings as well as against errors of commission or omission in the administration. During its formative years especially, the appeals procedure would be an important test of the bureau's effectiveness and efficiency an index of its efficient operation.

There are a variety of areas in which

such an appeals procedure could operate: the determination of coverage in an exclusion from the plan, the relationship between a contributor and the administration with respect to such matters as remuneration, accommodations, location, etc.; the relationship between a group practice or any other agency and the administration; the entitlement to benefits and so on. These and presumably other matters may be a source of grievance and machinery should exist for the right of appeal, the right to an impartial hearing and to review if the grievance is well founded.

It is noteworthy that the draft Bill

for a Health Insurance Act contained in the Hearby Report includes a provision for the determination of questions (section 11 of the draft Bill). Report of the Advisory Committee on Health Insurance, 1949. We do not transfer the specific provision in that draft. We merely draw the fact to your attention.

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believe the appeals procedure should also allow for

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to a central authority. We favor local boards necessary

tative in character and including lay as well as professional



members. It may be that there should be a body beyond the local board to which an appeal could be carried but we feel that the procedure should not be unduly complicated, costly or time-consuming in its operations. Boards should hear appeals promptly and without excessive formality, and make their decisions as soon after as possible. If an appeal is carried to a higher (and final) authority, there again appeals should be handled with despatch.

#### ADVISORY COUNCIL

We advocate the establishment of an Advisory Council whose function it should be to review and be consulted on policy matters. It should be provided with data which would enable it to evaluate the program and to make suggestions for its improvement or modification. It should be consulted on subjects such as extension or introduction of new services, cost factors, expansion or reorganization of facilities, relationships with professional personnel and the like. While it is not incumbent upon a government to take advice of those who give it, even on request, we believe that advice should be sought on the assumption that no government is infallible. Critical appraisal by a carefully appointed and representative committee can be of an inestimable value to any government program.

As to its composition, the Advisory Council should consist of representatives of interested groups in the Province, both lay and professional, representing those who are beneficiaries of the program and those who will be providing it. We envisage on the



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We suggest the establishment of an Advisory Council whose function it should be to review and be consulted on policy matters. It should be provided with data which would enable it to evaluate the program and to make suggestions for its improvement or modification. It should be consulted on subjects such as expansion or introduction of new services, cost factors, expansion or reorganization of facilities, relationships with professional personnel and the like. While it is not intended upon a government to give advice of those who give it, even on request, we believe that advice should be sought on the program and no government is infallible. Officially appointed and representative members can be of an invaluable value to any government program.

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1 consumer side, representation from organized labour,  
2 agriculture, and other such groups in the community; and  
3 on the professional side, not only the medical profession  
4 but also representatives of associations of dentists,  
5 nurses, social workers and others.

6 In addition to an Advisory Council  
7 with relatively broad terms of reference, there is room  
8 also for advisory committees on technical matters. The  
9 need for these would seem to be obvious and we do not feel  
10 that we should elaborate on this.

11  
12 GENERAL OBSERVATIONS

13 We have in this brief confined our-  
14 selves in very large measure to giving you a brief outline  
15 of the kind of public health care program that we think  
16 should be introduced in this Province. In doing so, we  
17 have dealt with some of the terms of reference which are  
18 the basis for your inquiries. There are others which we  
19 have not been able to deal with, such as estimates of  
20 costs, present and future, since the necessary data are  
21 not readily available to us. We presume that you will be  
22 able to arrive at conclusions on this subject from others  
23 with greater expertise.

24 Our main purpose is to draw attention  
25 to the very great need for more extended and improved  
26 health care services than now exist and to point to one  
27 way of solving this problem. What we are advocating is  
28 neither unique nor novel. Public health care programs  
29 are to be found throughout the civilized world and many  
30 of them have existed for a good many years. In terms of





1 this aspect of its social security program, Canada is  
2 still a long way behind other countries. We believe this  
3 deficiency should be remedied as soon as possible. We  
4 earnestly hope that your Commission will contribute in  
5 large measure to providing the Canadian people with the  
6 kind and the amount of health care that they require.

7 Respectfully submitted,

8 Nova Scotia Federation of Labour (C.L.C.)



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Very Sincerely,  
Hon. Justice Federation of Labour (C.I.)



pw

1 THE CHAIRMAN: Thank you, Mr. McKay.

2 I think there is an observation I would  
3 like to make, and I think you will appreciate why it is  
4 necessary that I should make it. When the Commission  
5 advertised its sittings it also advertised the manner in  
6 which it would conduct its proceedings and receive submis-  
7 sions and would ask those who were to come before it to  
8 summarize the brief or submission, and also where recommen-  
9 dations were being put forward, to give the Commission  
10 some information on what the cost of these recommendations  
11 might come to, and also where the money might come from.  
12 You have, in a general way, dealt with the third aspect;  
13 you say just get it out of the consolidated revenue fund.  
14 But otherwise, in the manner in which the brief came, we  
15 have departed from what had been the advertised manner in  
16 which we would receive submissions, and there is nobody  
17 offended at that having been done.

18 I would like to suggest that you might pass  
19 the word along to your associates in other places, in  
20 other Provinces, that we couldn't expect to make a depar-  
21 ture for any one body, whether it is a labour body or the  
22 Canadian Mental Association or the Dental Association, to  
23 make a special rule for any one group, and the rules  
24 which the Commission has laid down we will expect that  
25 they be adhered to.

26 Now, you would appreciate that that is a  
27 fair request, and I would appreciate it if you would  
28 discuss this matter with your associates and those who  
29 may be presenting similar briefs in other Provinces. We  
30 had time to listen to your very interesting brief because

I think there is an observation I would like to make, and I think you will appreciate why it is necessary that I should make it. When the Commission advertised the sittings it also advertised the manner in which it would conduct its proceedings and receive submissions and would ask those who were to come before it to summarise the brief or submission, and also where recommendations were being put forward, to give the Commission some information on what the cost of these recommendations might come to, and also where the money might come from. You have, in a general way, dealt with the third aspect; you say just get it out of the consolidated revenue fund. But otherwise, in the manner in which the brief came, we have departed from what had been the advertised manner in which we would receive submissions, and there is nobody offended at that having been done.

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1 others had complied with the regulations; that is why we  
2 are up to date, and we might not be quite so fortunate at  
3 some other time at some other place.

4 Now, any questions, gentlemen?

5 COMMISSIONER McCUTCHEON: I would assume,  
6 Mr. Chairman, that while the gentlemen in Nova Scotia  
7 might not have the data necessary to give estimates as to  
8 present costs and to future costs based on their recommen-  
9 dations, the Canadian Labour Congress, with which they  
10 are affiliated, will have the experts who can produce  
11 this information for us.

12 MR. McKAY: Yes.

13 THE CHAIRMAN: We will be looking for it at  
14 some time.

15 MR. ALLEN: As I said at the beginning of  
16 the submission, the Federation of Labour and another repre-  
17 sentative of the Federation of Labour had in mind presen-  
18 ting the brief to this submission, but owing to the fact  
19 of union business they were unable to be here, and they  
20 would have been able to answer some of the questions the  
21 Commission might want to ask them. But we are part of the  
22 Canadian Labour Congress, which will be presenting a brief  
23 to you, and if there is anything further they will probably  
24 pick up as they go along. If there is anything else you  
25 wish we will only be too glad to be able to do it. If you  
26 wanted a question probably on where the money is coming  
27 from, probably we can have some ideas on that, if you wish.

28 THE CHAIRMAN: Well, what is your idea?  
29 Where is it going to come from?

30 MR. ALLEN: I will ask Mr. Bell to answer



1 I am glad to see that the committee is so busy.  
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1 MR. BELL: Prior to the preliminary discus-  
2 sions there was a question that was raised as to what  
3 recommendations we could make as to the cost of it, and  
4 in the general examination of the needs of a national  
5 health plan it was brought out to us in our research that  
6 many other countries which are less economically advanced  
7 as our own in Canada have a national health plan operating.  
8 The listings that we looked over at one time showed a  
9 total of some 37 countries in the world, practically all  
10 of the European countries, South American countries ---

11 THE CHAIRMAN: I don't want to cut down what  
12 might be a propaganda answer in support of your brief.  
13 What we are concerned with is where in Canada will the  
14 money come from?

15 MR. BELL: We feel the transfers that are  
16 made, certainly should go a long way in supplying the  
17 health needs of the country.

18 COMMISSIONER FIRESTONE: Mr. Chairman, may I  
19 pursue this question a little bit further?

20 This Commission is very much interested, as  
21 you understand, in trying to find out what some of the  
22 proposals that are being made will cost, and where the  
23 money will come from. We also appreciate that to give a  
24 thorough answer may need a little work and a little consi-  
25 deration, and we are here particularly interested in the  
26 views of the Nova Scotia Federation of Labour. I realize  
27 we will get some answers from the Canadian Labour Congress,  
28 but while we are here we would like to have your views,  
29 and similar to what we said yesterday to the Medical  
30 Society of Nova Scotia, we wanted the Medical Society of





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1 Nova Scotia's views. So if I may pursue this question of  
2 financing a little further.

3 I take it when one talks about financing  
4 one wants to know how much one has to finance, and there-  
5 fore one must start out with a sort of overall figure. I  
6 presume you have access to the information of the Canadian  
7 Congress of Labour as to the overall cost and that part  
8 of that whole will be part of the cost for Nova Scotia.  
9 Would it be possible for you at a subsequent date to tell  
10 us what you would estimate would be the cost of a compre-  
11 hensive health and medical insurance program for Nova  
12 Scotia?

13 MR.BELL: Yes, we will. And further to  
14 that, we feel we wouldn't want to leave this Commission,  
15 at least on behalf of the people we represent, without  
16 making this general observation, that actually the people,  
17 particularly the people we represent, pay well for the  
18 services, and we feel that if the payments they were  
19 making were re-distributed in a certain way where the  
20 public interest as a whole would be taken into account,  
21 in the final analysis it would not cost as much as they  
22 are paying now in the high drug costs and the high costs  
23 to the medical people and other health care institutions  
24 and organizations that are now operating, private and  
25 otherwise, pre-payment schemes, and what have you.

26 COMMISSIONER FIRESTONE: Let's assume that  
27 at some stage we will get from you a figure of what this  
28 program will cost. We then go to the next stage where  
29 you advise us where that money will come from. If I may  
30 pursue this aspect a little further, you make the point in







1 your brief that you expect the bulk of it to come from the  
2 Federal Government, and I quote from page 16: "The Federal  
3 Government alone has the necessary tax resources and the  
4 ability to effect a re-distribution of its revenues in an  
5 equitable way". I take it from what you are saying on  
6 page 16 that you are not in favour, or are you in favour,  
7 of some of the costs of such a comprehensive health insu-  
8 rance program to be paid by premiums or contributions  
9 from those who will be benefiting from such a scheme and  
10 who are in a position to pay it. Are you in favour of  
11 such contributions?

12 MR. BELL: No. Our principal objection to  
13 the pre-payment scheme or schemes operated by a Provincial  
14 Government in co-operation with an overall national plan -  
15 we feel there should be a national health plan where the  
16 plan will be available to all citizens of the country;  
17 and as far as the financing is concerned, we feel that  
18 perhaps in the administration of such a plan, that can be  
19 worked out with the Provincial Governments and there  
20 should be part of the Provincial-Dominion negotiations  
21 on the sharing of tax revenues that they have carried on  
22 in the past since the Federal Government has taken over  
23 income taxes and corporation taxes.

24 COMMISSIONER STRACHAN: You haven't told us,  
25 sir, where this money is coming from.

26 MR. ALLEN: I may say that there will be a  
27 supplementary brief on some of those things you want.  
28 We find ourselves in a somewhat embarrassing position in  
29 the sense that we didn't have anything to do with drawing  
30 the brief up.



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29 the sense that we didn't have anything to do with drawing  
30 the lines up.





1 COMMISSIONER FIRESTONE: May I just say  
2 this - this would be very helpful - perhaps I can indicate  
3 by asking some questions the sort of thing we are after,  
4 and we are really genuinely interested in your views  
5 rather than a quick answer on the spur of the moment. So  
6 we would be quite happy to have a written submission.  
7 But I think we should perhaps ask a few questions because  
8 we are interested in this question. Would that be helpful?

9 MR. ALLEN: Yes.

10 COMMISSIONER FIRESTONE: I take it that  
11 your objection is to contributions by those who benefit  
12 by the plan even though they could afford to pay for it.  
13 You see, you could have a comprehensive plan for those  
14 who cannot afford it by tax revenue, and those who can  
15 afford it pay themselves for it. But you still feel that  
16 those who can afford to pay for it, the Government should  
17 pay for it out of tax revenue.

18 MR. BELL: Yes, we feel that the whole  
19 amount should be met, and we feel that the people in the  
20 upper income brackets could work out a similar technique  
21 that they have in other countries, that while they are  
22 eligible for the basic health services that the Government  
23 provides, because of their social position, perhaps  
24 making their own private arrangements, they do not  
25 actually utilize them to the extent that the ordinary  
26 people do. That is their own business; they don't want  
27 to stand in line and take the democratic procedure of  
28 servicing from their health officer and wish to have  
29 health services. We are not opposed to these other physi-  
30 cians operating for that class of people.





COMMISSIONER FINESTONE: May I just say

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by asking some questions the sort of thing we are after.

and we are really generally interested in your views

rather than a quick answer on the spot of the moment. So

we would be quite happy to have a written submission.

But I think we should perhaps ask a few questions now.

We are interested in this question. Would that be helpful?

MR. ALLEN: Yes.

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by the plan even though they could afford to pay for it.

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who cannot afford it by tax revenue, and those who can

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to spend the time and take the bureaucratic procedure of

servicing from their health officer and wish to have

health services. We are not opposed to these other pay-

ments operating for that class of people.



1                   COMMISSIONER FIRESTONE: To pursue the  
2 question a little further, you are therefore in favour of  
3 payment of general tax revenue. If increased services  
4 mean increased expenditures, and if these increased expen-  
5 ditures have to be paid by increased taxes, would you and  
6 your group be in favour of increased taxes to pay for such  
7 increased expenditures?

8                   MR. BELL: We think in conjunction with  
9 such a program the Government should look at its source  
10 of revenue itself to the point of not only calling upon  
11 people to meet the cost through personal income tax but  
12 also through upward revision of corporation tax and  
13 probably increases in succession duties and other means  
14 which are at their disposal.

15                  COMMISSIONER FIRESTONE: In other words,  
16 what you are saying is if increased revenue is required  
17 you would like to see it coming from all these sources,  
18 increased corporation taxes, increased income taxes and  
19 increased succession duty?

20                  MR. BELL: Yes.

21                  COMMISSIONER FIRESTONE: Would it be possible  
22 in the supplementary submission that you would give us  
23 your views as to whether your membership would support  
24 such increased taxes?

25                  MR. BELL: Our members and industrial  
26 workers are at the present time, a large part of them,  
27 covered by pre-paid private plans. It is our view that  
28 the premiums they are presently paying in private plans,  
29 if they were brought into a Government scheme, with the  
30 actuarial advantages there, we think there would be very



...the ...

2 question a little further, you are therefore in favour of

3 ...

4 mean increased expenditures, and in these increased expenditures

5 ...

6 your group be in favour of increased taxes to pay for such

7 increased expenditures?

8 MR. BELL: We think in conjunction with

9 ...

10 of revenue ...

11 people to meet the cost through personal income tax but

12 also through upward rotation of corporation tax and

13 probably increases in succession duties and other means

14 which are at their disposal.

15 ...

16 what you are saying is if increased revenue is required

17 you would like to see it coming from all these sources,

18 increased corporation taxes, increased income taxes and

19 increased succession duties?

20

21 COMMISSIONER FLETCHER: Would it be possible

22 in the supplementary estimation that you would give us

23 your views as to whether your membership would support

24 such increased taxes?

25 MR. BELL: Our members and industrial

26 workers are at the present time, a large part of them,

27 covered by pay-paid private plans. It is our view that

28 ...

29 ...

30 ...

31 actual advantages there, we think there would be very





1 little added cost to the industrial workers and their  
2 families, but there would be a wider range of services  
3 for their people because the premiums they are now paying  
4 to the private plans would be taken over by the Government.

5 COMMISSIONER FIRESTONE: This is on the  
6 assumption that this will be the case, but we have also  
7 to go on the assumption that this will not be the case.

8 MR. BELL: Supplemented, of course, by other  
9 revenues from the sources I have mentioned.

10 COMMISSIONER FIRESTONE: I take it we will  
11 get an answer from your membership, because somebody has  
12 to pay for it, and this includes industrial workers, and  
13 we are just wondering if your membership, which is a large  
14 membership, would be in favour of it.

15 MR. BELL: Mr. Chairman, I know that perhaps  
16 some of the medical profession may not feel too kindly  
17 towards us at the moment in suggesting that they go on  
18 salary. But I would wish to point out that it has been  
19 pointed out to us that statistics in Nova Scotia of those  
20 physicians who are on salary are 27%.

21 COMMISSIONER FIRESTONE: Again on page 16,  
22 you have been emphasizing that the bulk of contributions  
23 should come from the Federal Government because of its  
24 greater ability to re-distribute incomes, and you refer  
25 in your remarks to income and corporation tax. I presume  
26 you are aware that after March, 1962, the Provinces will  
27 be in a position to collect their own income and corpora-  
28 tion taxes, and if they impose them they can be collected  
29 at their request by the Federal Government. You are aware  
30 of that?



families, but there would be a wider range of services

COMMISSIONER: This is on the

assumption that this will be the case, but we have also

to go on the assumption that this will not be the case.

MR. BELL: Supplemented, of course, by other

revenues from the sources I have mentioned.

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get an answer from your membership, because somebody has

to pay for it, and this includes industrial workers, and

we are just wondering if your membership, which is a large

membership, would be in favour of it.

MR. BELL: Mr. Chairman, I know that perhaps

some of the medical profession may not feel too kindly

towards us at the moment in suggesting that they go on

salary. But I would wish to point out that it has been

pointed out to us that attention to how doctors of those

relationships who are on salary are paid.

COMMISSIONER: Again on page 16,

you have been emphasizing that the bulk of contributions

should come from the Federal Government because of its

greater ability to redistribute income, and you refer

in your remarks to income and corporation tax. I presume

you are aware that after March, 1962, the Province will

be in a position to collect their own income and corpora-

tion taxes, and it may happen then they can be collected

at their request by the Federal Government. You are aware

of that?





1 MR. BELL: Yes.

2 COMMISSIONER FIRESTONE: I take it that if  
3 a comprehensive health insurance scheme is introduced in  
4 the Province of Nova Scotia and the Province has the major  
5 responsibility in the health insurance plan that they have,  
6 that your Nova Scotia Federation of Labour would be in  
7 favour of higher taxes being imposed by the Province of  
8 Nova Scotia to pay for the extra expense involved in the  
9 scheme?

10 MR. BELL: I think our opinion on the ques-  
11 tion of the Provincial-Dominion arrangement of rebating  
12 back to the Provinces, we would prefer to have the present  
13 arrangements continued, perhaps with a greater rebate to  
14 the Province, because we join the Provincial Government  
15 in advocating the need for greater economic aid for this  
16 part of undeveloped Canada. But at the same time if that  
17 does come about, I guess we will have to try to introduce  
18 a plan on a Provincial basis, which would probably be far  
19 short of the national scheme. In that I see a breakdown  
20 of national unity in the country, and personally I am  
21 not that pessimistic; I think we are going to have national  
22 co-ordination throughout the country, and it will be for  
23 the Federal Government to collect the taxes and work out  
24 a satisfactory agreement of tax rebates for the Provinces.

25 COMMISSIONER FIRESTONE: Can we take it that  
26 you will be submitting a supplementary brief on this  
27 point without going into the Provincial and Dominion  
28 relations? And do you feel that the resources of the  
29 Province may be inadequate to deal with the financing of  
30 a comprehensive program even though they will have the





MR. BELL: Yes.

COMMISSIONER WILSON: I take it that in

a comprehensive health insurance scheme is introduced in

the Province of Nova Scotia and the Province has the major

responsibility in the health insurance plan that they have

that your Nova Scotia Federation of Labour would be in

favour of higher taxes being imposed by the Province of

Nova Scotia to pay for the extra expense involved in the

MR. BELL: I think our opinion on the ques-

tion of the Provincial-Dominion arrangement of remaining

back to the Province, we would prefer to have the present

arrangement continued, perhaps with a greater rebate to

the Province, because we join the Provincial Government

in advocating the need for greater economic aid for this

part of undeveloped Canada, but at the same time if that

does come about, I guess we will have to try to introduce

a plan as a Provincial basis, which would probably be not

short of the national scheme. In that I see a breakdown

of national unity in the country, and personally I am

not that pessimistic; I think we are going to have national

co-ordination throughout the country, and it will be for

the Federal Government to collect the taxes and work out

a satisfactory system of tax rebates for the Province.

COMMISSIONER WILSON: Can we take it that

you will be submitting a supplementary bill on this

point without going into the Provincial and Dominion

relations? And do you feel that the resources of the

Province may be inadequate to deal with the financing of

a comprehensive program even though they will have the



1 right to collect taxes directly, and that you will also  
2 indicate how and to what extent the Federal Government  
3 will contribute so that the Province will have a health  
4 care program which would be comparable in standards to  
5 the rest of Canada, in the interests of uniformity and in  
6 the interests of providing everyone with ample opportunity  
7 to obtain adequate health care? Can we have such addi-  
8 tional information from you?

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1 MR. BELL: You can rest assured that our  
2 position on that would be that we would want comparable  
3 coverage on all the social services that Government should  
4 supply.

5 COMMISSIONER FIRESTONE: But I take it that  
6 you will indicate in your supplementary information how  
7 this should be achieved, and the formula that could be  
8 used to make up for any such deficiencies?

9 MR. BELL: Right.

10 THE CHAIRMAN: One question arose out of an  
11 answer you gave to Dr. Firestone, where you mentioned that  
12 those in the upper brackets might not wish to take advan-  
13 tage of a general health service, they could get the  
14 service elsewhere. Does that imply that you are in favour  
15 of a contracting-out provision?

16 MR. BELL: Yes. I am not too familiar with  
17 the British system so far as that is concerned, but I do  
18 understand that under the British plan it is possible for  
19 the people who wish special services to obtain them from  
20 doctors who are either in the plan or who are out of the  
21 plan, and those who are in, I understand, do not submit  
22 bills to the National Health Ministry for the services  
23 rendered. I believe the specialists in Great Britain -  
24 they actually do provide services to people who do not  
25 make it a point of applying for benefits under the  
26 National Health plan.

27 THE CHAIRMAN: Well, that is the contracting-  
28 out provision.

29 MR. BELL: But, at the same time, these  
30 same practitioners and specialists could still take on



THE CHAIRMAN: The question is, will you  
be satisfied with the present arrangement?

4 Supply.

5 COMMISSIONER FIRESTONE: But I take it that

6 you will indicate in your supplementary information how

7 this should be achieved, and the formula that could be

8 used to make up for any such deficiencies?

9 MR. BELL: Right.

10 THE CHAIRMAN: One question arose out of an

11 answer given by Mr. Firestone, namely, how could you

12 those in the upper brackets might not wish to take advan-

13 tage of a general health service, they could get the

14 service themselves, but they will not do so.

15 It is a question of incentives.

16 MR. BELL: Yes, I am not too familiar with

17 the British system as far as that is concerned, but I do

18 understand that under the British plan it is possible for

19 the people who wish special services to obtain them from

20 doctors who are either in the plan or who are out of the

21 plan, and that is the case in the United States, I understand.

22 It is the fact that the British plan is not a

23 complete one, but that it is a partial one.

24 It is a partial one, and it is not a complete one.

25 It is a partial one, and it is not a complete one.

26 It is a partial one, and it is not a complete one.

27 THE CHAIRMAN: Well, that is the contrasting

28 out provision.

29 MR. BELL: But, at the same time, these

30 some practitioners and specialists could still take on



1 cases under the National Health plan.

2 THE CHAIRMAN: I think we understand the  
3 system. I am asking you if you are in favour of it, or  
4 against it?

5 MR. BELL: Yes, I am in favour of it.

6 THE CHAIRMAN: And would you have it include  
7 everyone, with the right to contract-out, would you limit  
8 it to somebody whose income was only above a certain  
9 figure, or below a certain figure?

10 MR. BELL: I think the economics of the  
11 thing would govern the situation. From our point of view,  
12 we cannot visualize a person in a low income bracket  
13 paying for coverage and then going privately to a physician  
14 for care.

15 THE CHAIRMAN: That is the argument, I know.  
16 Could you give me an answer without putting forward an  
17 argument?

18 MR. BELL: I am agreeable, Mr. Chairman,  
19 that the contracting-out provision should prevail.

20 THE CHAIRMAN: And apply to everybody?

21 MR. BELL: Yes.

22 COMMISSIONER McCUTCHEON: Mr. Chairman,  
23 could I ask one question without using the very long and  
24 involved definitions you have given as to what a compre-  
25 hensive health scheme implies. Have you given any consi-  
26 deration to the position of, I wouldn't know how many,  
27 possibly some 50 voluntary agencies engaged in the health  
28 field in Canada today, some of whom we have heard from  
29 here, others whom we will hear from elsewhere. To make  
30 a specific example, would you be in favour of the Canadian





THE CHAIRMAN: I think no longer the

system. I am asking you if you are in favour of it, or

against it?

MR. BELL: Yes, I am in favour of it.

THE CHAIRMAN: And would you have it include

everyone, with the right to participate, would you limit

it to somebody whose income was only above a certain

figure, or below a certain figure?

MR. BELL: I think the economics of the

thing would govern the situation. From one point of view,

we cannot visualize a person in a low income bracket

being able to contribute to the system.

for care.

THE CHAIRMAN: And apply to everybody?

the various definitions you have given as to what a corporate

negative public scheme implies. Have you given any consideration

to the position of, I wouldn't know how many,

possibly some 50 voluntary agencies engaged in the health

field in Canada today, some of whom we have heard from

here, others whom we will hear from elsewhere. It may

a specific example, would you be in favour of the Canadian



1 Red Cross Society giving up its blood bank facilities?  
2 Are all these things, the Victorian Order of Nurses, to  
3 go out of existence, are all these things to be taken over  
4 by Government?  
5 MR. BELL: Only if they become a threat to  
6 a fully comprehensive plan. If it is possible to bring in  
7 a fully comprehensive national health plan, and these  
8 plans in no way interfere with the bringing of the natio-  
9 nal health scheme into effect, I think the voluntary orga-  
10 nizations should still exist, but if it is a case, for  
11 example, where the money that is now being directed to  
12 these organizations from the ordinary people through the  
13 United Appeal and that sort of thing, if as a result of  
14 the added contribution required of the average citizen  
15 through some form of increased taxation or what have you,  
16 only then I think would the problem arise. If it became  
17 that the cost of the health plan to the ordinary person  
18 was such that he was unable to pay his taxation and at  
19 the same time contribute to these public agencies, I think  
20 indirectly that would affect the public agencies in that  
21 roundabout and indirect way, because they depend now on the  
22 contributions of the ordinary citizen.

23 COMMISSIONER McCUTCHEON: By public agencies,  
24 do you mean the private voluntary agencies?

25 MR. BELL: Yes.

26 COMMISSIONER McCUTCHEON: May I suggest then  
27 that you do give that question, which I think is an impor-  
28 tant one, serious consideration, and let us have your  
29 views on the place that the private voluntary agency in  
30 this comprehensive scheme which you are recommending, and



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20 indirectly that would affect the public agencies in that  
21 roundabout and indirect way, because they depend now on the  
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23 COMMISSIONER MONTGOMERY: By public agencies  
24 do you mean the private voluntary agencies?  
25 Mr. BULL: Yes.  
26 COMMISSIONER MONTGOMERY: May I suggest then  
27 that you do give that matter, which I think is an impor-  
28 tant one, serious consideration, and let us have your  
29 views on the place that the private voluntary agency in  
30 this comprehensive scheme which you are recommending, and





1 let us have those carefully considered views in your  
2 supplementary brief.

3 COMMISSIONER STRACHAN: I would like to  
4 refer to page 24, where you suggest that physicians might  
5 have the privilege of collective bargaining. In my under-  
6 standing, the strong arm of collective bargaining is the  
7 strike. Would you suggest that the physicians would have  
8 the right to strike? God forbid that they ever would be  
9 so inhuman to do so, and picket a hospital where your  
10 wife or your child was, so that they would receive no  
11 attention.

12 MR. BELL: Occasionally it is carried on on  
13 an individual basis. Refusal to come to a person in an  
14 emergency is a form of strike. We are not suggesting that  
15 that be encouraged or developed. We think that in a  
16 society in which the profit motive is eliminated, or  
17 narrowed to its smallest degree, that the chances or  
18 probability of strikes will be very small, because of the  
19 fact that as a general rule either one of the motives for  
20 strike action is the fact that you are making a contribu-  
21 tion at the expense of someone's profit, and in this  
22 situation that would not be the case.

23 COMMISSIONER STRACHAN: Is there no profit  
24 motive to a strike, for higher wages? You are referring  
25 to a profit motive. Is there no such thing as that in a  
26 strike for higher wages?

27 MR. BELL: Our experience of strikes is  
28 merely to try and catch up with the higher living costs  
29 that other agencies or other groups in society have  
30 imposed on us. That has been the cause of strikes as far



1 I have these cards in my hand.

2 COMMISSIONER BROWN: I would like to

3 refer to page 24, where you suggest that physicians might  
4 have the privilege of collective bargaining. In my opinion,  
5 starting, the strong arm of collective bargaining is the  
6 strike. Would you suggest that the physicians would have  
7 the right to strike? God forbid that they even would be  
8 so human to do so, and picket a hospital where your  
9 wife or your child was, as then they would receive no

10 MR. BROWN: Obviously it is a matter of  
11 an individual basis. Let's not come to a point in an  
12 emergency is a form of strike. We are not suggesting that  
13 that be encouraged or developed. We think that in a  
14 society in which the profit motive is eliminated, or  
15 narrowed to the smallest degree, if the chances of  
16 probability of strikes will be very small, because of the  
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18 strikes action is the fact that you are making a contribu-  
19 tion at the expense of someone's profit, and in this  
20 situation that would not be the case.

21 COMMISSIONER BROWN: Is there no point

22 motive to a strike for higher wages? You are referring  
23 to a profit motive. Is there no such thing as that in a  
24 strike for higher wages?

25 MR. BROWN: Our experience of strikes is

26 merely to try and control with the higher living costs  
27 that other agencies or other groups in society have  
28 imposed on us. That has been the case of strikes in the



1 as the trade union movement is concerned.

2 THE CHAIRMAN: May I suggest, Dr. Strachan,  
3 that the morality of strikes is beyond the scope of the  
4 inquiry that we are presently engaged in. The question was  
5 put to you, but I don't know that we need pursue it further.

6 MR. BELL: Mr. Chairman, I think that since  
7 this is a Nova Scotia submission, and we were hopeful that  
8 another trade union organization that is connected with  
9 hospital work, that is representing the non-professional  
10 people in the hospitals, would have appeared before you  
11 to perhaps bring to your attention the situation in regards  
12 as the doctor has brought out, and that is that since the  
13 introduction of the sales tax in the Province of Nova  
14 Scotia, a hospital commission has been set up, and that  
15 has indirectly interfered with the rights of collective  
16 bargaining of hospital employees to the point that wages  
17 for non-professional workers are paid, in this Province,  
18 \$75.00 per month, an unheard of wage, and secondly they  
19 are putting a wage-freeze on all non-professional people  
20 in the Province, by telling the hospital that their budget  
21 is limited and it does not include provision for wage  
22 increases, and since the hospital commission has come into  
23 effect, several workers have had wage cuts, and therefore  
24 you can see that this thing cuts both ways. I haven't  
25 heard of any strikes of non-professional employees in  
26 hospitals, and I don't think there will be any, but I  
27 suggest to you that they are working under conditions that  
28 are much more undesirable than many of the higher-paid  
29 professional employees in the hospital, and they have  
30 little recourse under the same type of set-up.





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4 inquiry that we are presently engaged in. The question was  
5 put to you, but I don't know that we need pursue it further.  
6 MR. BELL: Mr. Chairman, I think that there  
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8 another trade union organization that is connected with  
9 hospital work, that is representing the non-professional  
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19 are putting a wage freeze on all non-professional people  
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21 is limited and it does not include provision for wage  
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23 effect, several workers have had wage cuts, and therefore  
24 you can see that this thing cuts both ways. I haven't  
25 heard of any strikes of non-professional employees in  
26 hospitals, and I don't think there will be any, but I  
27 suggest to you that they are working under conditions that  
28 professional employees in the hospital, and they have  
29 little recourse under the same type of set-up.



1 THE CHAIRMAN: Do you know of any other  
2 Province that has put a sort of ceiling on the cost of  
3 operation of hospitals?

4 MR. BELL: We know that a similar plan  
5 operates in New Brunswick, and there we are happy to see  
6 that the situation is not comparable to that here in Nova  
7 Scotia.

8 THE CHAIRMAN: Are you aware that in the  
9 Province of Saskatchewan there has been a ceiling put on  
10 the expenditures of hospitals, on their budgets, which  
11 means a wage-freeze?

12 MR. BELL: We are not aware of the rights  
13 of collective bargaining being infringed upon in any other  
14 Province to the extent that it is in this particular  
15 Province.

16 THE CHAIRMAN: Anything else? Thank you  
17 gentlemen.

18 MR. BELL: We have a supplementary brief  
19 from the Halifax Labour Council. It was merely a re-stating  
20 of the Canadian Labour Congress. We merely wish to table  
21 that.

22 BRIEF OF HALIFAX-DARTMOUTH AND DISTRICT  
23 LABOUR COUNCIL (C.L.C) TO THE ROYAL  
COMMISSION ON HEALTH SERVICES

24 Halifax, N.S. November 1, 1961.

25 Gentlemen:-

26 Our Council represents approximately 20,000  
27 workers in the Halifax-Dartmouth area, and this membership,  
28 along with their families, constitutes a majority of the  
29 citizens of the region.

30 Our Council is aware of the hardships which



THE CHAIRMAN: Is there any other business?

Province that has put a sort of ceiling on the cost of

operation of hospitals?

MR. BELL: We know that a similar plan

operates in New Brunswick, and there we are happy to see

that the situation is not completely the same as in

Quebec.

THE CHAIRMAN: Are you aware that in the

Province of Saskatchewan there has been a ceiling put on

the expenditure of hospitals, on their budgets, which

is a very important matter.

MR. BELL: We are not aware of the rights

of collective bargaining being infringed upon in any other

Province in the country and it is highly important.

THE CHAIRMAN: Anything else? Thank you

gentlemen.

MR. BELL: We have a supplementary brief

from the Halifax Labour Council. It was merely a re-statement

of the Canadian Labour Congress. We merely wish to state

that.

COMMISSION ON HEALTH SERVICES  
LABOUR COUNCIL (C.L.C.) TO THE ROYAL  
COMMISSION ON HEALTH SERVICES

TO THE CHAIRMAN, THE CHAIRMAN OF THE

LABOUR COUNCIL

Our Council represents approximately 20,000

members in the Halifax region, and we are

glad to see that their views are being presented to

officials of the region.

Our Council is aware of the hardships which





1 many of our members have encountered insofar as bearing  
2 the cost of health services which are not covered by public  
3 or private health schemes.

4                   Recently our Council submitted a brief to  
5 the Restrictive Trades Practices Commission regarding the  
6 high cost of drugs, and in the preparation of that brief,  
7 it was brought out that health services' costs are beyond  
8 their means and are only taken care of as a result of  
9 other family necessities being curtailed.

10                   Our views on the health needs of the  
11 Canadian people are pretty well summed up in a resolution  
12 which was passed at the Third Constitutional Convention  
13 of the Canadian Labour Congress held in Montreal, April  
14 25th-29th, 1960. The resolution is herewith reprinted:-

15                   "RESOLVED that the Canadian Labour Congress  
16 reaffirms its belief in the need for a comprehensive  
17 national programme of health care that will ensure that  
18 for every citizen there is available whatever medical  
19 treatment he requires in whatever form he requires it,  
20 including preventive and diagnostic, as well as curative  
21 and rehabilitative services, drugs and appliances,  
22 provided by physicians, surgeons, dentists and other  
23 specialists and agencies; and

24                   "BE IT FURTHER RESOLVED that, in the opinion  
25 of the Congress, such a programme of health care should  
26 be effectively introduced and administered through a  
27 national health insurance plan; and

28                   "BE IT FURTHER RESOLVED that the Congress  
29 call upon the Federal Government to introduce such a plan,  
30 seeking, if necessary, the support of the provinces for



many of our members have encountered insofar as bearing the cost of health services which are not covered by public or private health schemes.

Recently our Council submitted a brief to the Restrictive Trades Practices Commission regarding the high cost of drugs, and in the preparation of that brief, it was brought out that health services' costs are beyond their means and are only taken care of as a result of other family necessities being curtailed.

Our views on the health needs of the Canadian people are pretty well summed up in a resolution which was passed at the Third Constitutional Convention of the Canadian Labour Congress held in Montreal, April 25th-29th, 1960. The resolution is herewith reprinted:-

"RESOLVED that the Canadian Labour Congress

reaffirms its belief in the need for a comprehensive national programme of health care that will ensure that for every citizen there is available whatever medical treatment he requires in whatever form he requires it;

"BE IT FURTHER RESOLVED that, in the opinion of the Congress, such a programme of health care should be effectively introduced and administered through a national health insurance plan; and

"BE IT FURTHER RESOLVED that the Congress call upon the Federal Government to introduce such a plan, and, in necessary, the support of the provinces for





1 its effective implementation, and "BE IT FURTHER RESOLVED  
2 that the Canadian Labour Congress and its affiliated and  
3 chartered organizations initiate and conduct a campaign  
4 to press for the establishment of such a plan forthwith".

5 One aspect of health services which is  
6 badly needed in the Halifax-Dartmouth area is adequate  
7 facilities for aged persons who are bedridden and those  
8 persons who are chronically ill and require institutional  
9 nursing care. Much of the private nursing care provided  
10 in this area entails a cost of \$30.00 - \$35.00 minimum to  
11 a much larger weekly charge.

12 Our provincial Federation of Labour has  
13 called upon the Provincial Government to introduce an  
14 inspection of these establishments, as many of them are  
15 not properly equipped for nursing care.

16 It is our view that persons of limited means  
17 should be entitled to free institutional nursing care and  
18 this should be borne by the three levels of government  
19 jointly.

20 We are aware of the fact that the Nova Scotia  
21 Federation of Labour and the Canadian Labour Congress will  
22 be preparing briefs in much greater detail to your Commis-  
23 sion, but our Council wished to take advantage of the  
24 opportunity of submitting this brief outline of our views  
25 while your Commission is sitting in Halifax.

26 Respectfully submitted.

27 Signed. D.J. Gannon, President

28 THE SECRETARY: The submission that was  
29 read will be known as Exhibit No. 16, and the one to be  
30 filed now will be Exhibit No. 17.



the effective implementation, and "BE IT FURTHER RESOLVED  
that the Canadian Labour Congress and its affiliated and  
chartered organizations initiate and conduct a campaign  
to press for the establishment of such a plan forthwith."

One aspect of health services which is  
badly needed in the Halifax-Dartmouth area is adequate  
facilities for aged persons who are bedridden and those  
persons who are chronically ill and require institutional  
nursing care. Much of the private nursing care provided  
in this area entails a cost of \$30.00 - \$35.00 minimum to  
a much larger weekly charge.

Our provincial Federation of Labour has  
called upon the Provincial Government to introduce an  
inspection of these establishments, as many of them are  
not properly equipped for nursing care.  
It is our view that persons of limited means

should be entitled to free institutional nursing care and  
this should be borne by the three levels of government  
jointly.

Signed, D.J. Gannon, President

THE SECRETARY: The submission that was

read will be known as Exhibit No. 16, and the one to be

filed now will be Exhibit No. 17.



--- EXHIBIT NO. 16: Submission of the Nova Scotia  
Federation of Labour.

--- EXHIBIT NO. 17: Brief of Halifax-Dartmouth and Dis-  
trict Labour Council.

THE CHAIRMAN: We will adjourn now until  
2 o'clock to hear the submission of the Nova Scotia  
Division of the Canadian Mental Health Association.

--- Luncheon adjournment



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THE CHAIRMAN: All right.

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dpw 1 --- On resuming at 2 p.m.

2 THE CHAIRMAN: We are now ready to hear the  
3 presentation from the Nova Scotia Division of the Canadian  
4 Mental Health Association.

5 REV. CAMPBELL: Mr. Chairman and Commissioners,  
6 I am Father Campbell from Antigonish, and I am functioning  
7 today as a layman in the field of mental health, and with  
8 me, representing the Nova Scotia Division, are, the Chair-  
9 man of our Scientific Planning Committee, Dr. Shane, psy-  
10 chiatrist of Halifax, Dr. R.O. Jones, psychiatrist, head  
11 of the Department of Psychiatry of the School of Medicine,  
12 Dalhousie University, Dr. Solomon Hirsch, psychiatrist,  
13 Halifax and Mr. Andrew Crook, the Executive Director of  
14 the Nova Scotia Division.

15 Last year, Mr. Chairman, you will recall  
16 that a Member of Parliament for Montreal, Mr. Allan  
17 MacNaughton, presented a resolution to the House of  
18 Commons concerning an investigation into the mental health  
19 needs of the people of Canada. We were very happy to  
20 hear that in a month or so following that, the Government  
21 proposed to set up a Commission to investigate all of the  
22 health needs of the people of Canada, and we were encouraged  
23 to hear that the Terms of Reference were to take care of  
24 the mental health needs. We are very appreciative for  
25 this action on the part of the Government and the Commis-  
26 sion.

27 Our brief has been prepared by a committee  
28 which we call the Scientific Planning Committee. The  
29 Chairman is Dr. Jones. These people have put in a great  
30 deal of their time and effort on a voluntary basis during



--- On resuming at 2 p.m.

THE CHAIRMAN: We are now ready to hear the presentation from the Nova Scotia Division of the Canadian Mental Health Association.

REV. CAMPBELL: Mr. Chairman and Commissioners, I am Father Campbell from Antigonish, and I am functioning today as a layman in the field of mental health, and with me representing the Nova Scotia Division of the Canadian Mental Health Association. I am very pleased to be here today, and I am sure that the presentation will be of interest to you. I am sure that the presentation will be of interest to you. I am sure that the presentation will be of interest to you.

last year, Mr. Chairman, you will recall that a Member of Parliament for Montreal, Mr. Allan MacNaughton, presented a resolution to the House of Commons concerning an investigation into the mental health needs of the people of Canada. We were very happy to hear that in a month or so following that, the Government proposed to set up a Commission to investigate all of the health needs of the people of Canada, and we were encouraged to hear that the Terms of Reference were to take care of the mental health needs. We are very appreciative for this action on the part of the Government and the Commission which we call the Scientific Planning Committee. The Chairman is Dr. Jones. These people have put in a great deal of their time and effort on a voluntary basis during





1 the past year and have distilled their own opinions concer-  
2 ning an adequate mental health program for the Province of  
3 Nova Scotia. We are not questioning in our brief motives  
4 of any governmental department or any other group or asso-  
5 ciation which operates in the mental health area in this  
6 Province. We feel there are some excellent features of  
7 the mental health program in our Province, but there are  
8 some weaknesses and we are sure other agencies concerned  
9 with the problem are aware of these as well. We know that  
10 you are aware of the extent of the problem. Statistics  
11 are being thrown around in all directions: about half of  
12 our hospital beds are taken up by mental patients in the  
13 country. We have figures which seem to indicate that at  
14 least one of every 12 will spend some time in a hospital  
15 for treatment of mental illness. In Nova Scotia, however,  
16 we have a fairly reliable set of statistics as a result  
17 of a study carried on by Dr. Layton and his associates in  
18 the Stirling County study, and he showed, through the  
19 consideration of ~~the number~~ of patients experienced in  
20 that county, from a consideration of interviews with  
21 doctors in that county, and through interviews of random  
22 samples of people within the county, that the prevalence  
23 rate of mental illness was 375 per 1,000 of the population.  
24 That would be, of course, approximately 37% of the people  
25 in all age groups in that county were significantly  
26 impaired mentally, so significantly impaired that they  
27 needed expert treatment.

28                   The principles which I am sure you have  
29 found expressed in the brief are these: that patients or  
30 individuals suffering from mental illness must receive the





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 2 ing an adequate mental health program for the Province of  
 3 New Scotia. We are not questioning in our latest review  
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 19 consideration of the number of patients experienced in  
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 21 doctors in that county, and through interviews of random  
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 23 rate of mental illness was 3% per 1,000 of the population.  
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 26 mentally ill, so significantly indicated that they  
 27 would be of some use.

28 The original when I saw you was

29

30 individuals suffering from mental illness must receive the



1 same opportunities for treatment as those who are suffering  
2 from physical forms of illness. We realize that the type,  
3 quality and form of treatments will differ, but we feel  
4 that all of our citizens must have the same opportunities  
5 for treatment of their mental ills. There is no principle  
6 operating in the brief that the diagnosis, treatment and  
7 rehabilitation and so on should take place as close as  
8 possible to the homes of the patients. Therefore, we are  
9 in favour of small decentralizations within the Province,  
10 and also in favour of regionalization of our services.

11 We are in full accord with the trend that  
12 is now taking place within mental health services in the  
13 Province whereby community mental health clinics have been  
14 established in at least eight communities. These community  
15 mental health centres are established on a co-operative  
16 basis between the Provincial Government and the local  
17 community concerned; that is, citizens actively engaged in  
18 improving mental health services in this area, and our  
19 Association has taken a very prominent role in the esta-  
20 blishment and organization of the clinics.

21 So, we feel that the common opinion in  
22 psychiatric practice is that people should be treated  
23 early, that there should be facilities for prevention,  
24 adequate follow-up, rehabilitation, and this can best be  
25 had if we decentralize and regionalize our services.

26 Finally, you find another difficulty which  
27 we realize: the acute shortage of professional and ade-  
28 quately trained personnel in the health field. We know  
29 from experience in some of our efforts that we can esta-  
30 blish a clinic, but the personnel is not available. They







1 are available, but perhaps the opportunities in other  
2 Provinces are much better for these men and women. So,  
3 we feel that we should have adequate facilities and  
4 encouragement for young men and women to enter the mental  
5 health professions -- psychiatry, psychology, psychiatric  
6 nursing work, and so forth -- and if any of our programs  
7 are to succeed, we must have the personnel.

8 Many of our principles and opinions and  
9 ideas are to be found in the current literature in psychi-  
10 atry, and I would like to draw your attention to one  
11 already mentioned, the Stirling County Study carried on  
12 in the Province of Nova Scotia, and the series of studies  
13 carried on by the Commission on Mental Illness and Health  
14 in the United States, presented to the Congress and the  
15 various legislatures of the various American States.

16 I would also want to say that we are only  
17 one of nine provincial associations which will present  
18 briefs to you across the country, and I know that they  
19 will be presenting you with particular regional problems,  
20 and I also am aware of the fact that the national office  
21 will have additional recommendations and additional infor-  
22 mation to pass on to you as a result of the questions or  
23 information you seek from the local branches. Therefore,  
24 the national office will present a point of view from the  
25 national aspect of the mental health problem.

26 I want to say as well that Dr. Griffin, who  
27 is the National Director of the Association, is here in an  
28 advisory capacity to us, and he is not present on this  
29 board which represents our Association.

30 I want to thank you for the opportunity to



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1 present the brief to you, and with your indulgence, and  
2 presuming your permission, I will ask Dr. Shane to present  
3 the particular conclusions or recommendations -- about 12  
4 in number -- to you.

5 THE CHAIRMAN: Thank you.

6 SUBMISSION OF THE NOVA SCOTIA DIVISION OF THE  
7 CANADIAN MENTAL HEALTH ASSOCIATION.

8 Appearances: Rev. D.F. Campbell, President  
9 Aubrey Shane, M.D., Chairman,  
10 Scientific Planning Committee  
11 R.O. Jones  
12 Solomon Hirsch, M.D., Board Member

12 --- EXHIBIT NO. 18: Submission of the Nova Scotia Division  
13 of the Canadian Mental Health Association.  
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SUBMISSION OF  
THE CANADIAN MENTAL HEALTH ASSOCIATION  
NOVA SCOTIA DIVISION

FOREWORD

1. The Nova Scotia Division, The Canadian Mental Health Association, is the oldest voluntary association of its kind in Canada, having been founded in Halifax in 1908. The objectives of the Nova Scotia Division can be stated briefly as "promoting the establishment of the best possible facilities for the care, treatment and rehabilitation of those suffering from mental disorders and to promote practical programs designed to prevent mental illness and to protect and promote mental health".
2. From its early beginning, the Nova Scotia Division has made a significant contribution to the mental health of the province in keeping with the objectives outlined above. It has assumed, to a greater or lesser degree, responsibility for such things as the following:-
  - was instrumental in the establishment in Truro of a school for mentally retarded children
  - promoting the establishment of a Department of Psychiatry at Dalhousie University.
  - promoting improved facilities in Nova Scotia mental institutions
  - promoting the establishment of community mental health clinics in seven provincial centres with consequent responsibility for financing part of the operation of these clinics.
  - the development, through public education programs, of a greater awareness among the public of the

SUBMISSION OF

NOVA SCOTIA DIVISION

FORWARD

The Nova Scotia Division, The Canadian Mental Health Association, is the oldest voluntary association of its kind in Canada, having been founded in Halifax in 1906. The objectives of the Nova Scotia Division can be stated briefly as "promoting the establishment of the best possible facilities for the care, treatment and rehabilitation of those suffering from mental disorders and to promote practical programs designed to prevent mental illness and to protect and promote mental health".

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1 needs of the mentally ill and a healthier attitude  
2 towards mental illness itself

3 - the development of active volunteer programs in  
4 most of our mental institutions which resulted  
5 in over 1500 individuals and vast numbers of  
6 community groups coming into our hospitals pro-  
7 viding social, recreational, and occupational  
8 activity for the patients

9 3. The amount of public support which the Nova Scotia  
10 Division is increasingly receiving for its program is  
11 indicated by its increased returns from financial  
12 campaigns and donations. This has increased from  
13 \$1,900.00 in 1954 to \$54,000.00 in 1960 with \$80,000.00  
14 projected for 1961. From the information at hand no  
15 other voluntary health organization in a period of seven  
16 years has commanded such increased widespread public  
17 support.

18 4. The Nova Scotia Division acknowledges the need for a  
19 comprehensive study of all health facilities and  
20 services. It further acknowledge the need for improved  
21 methods of care in the many fields of health. It does  
22 at this time, however, wish to draw attention to its  
23 special area of concern, mental health. Our attention  
24 therefore will be directed to a brief examination of this  
25 problem, present methods of ~~combating it~~ and suggestions  
26 for coping more adequately with it in the hopes that  
27 fewer Canadians need suffer the tragic effects of serious  
28 mental illnesses and that more of our citizens can  
29 enjoy a ~~more~~ healthy life with consequent benefit to all  
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5. It is in this spirit that the Nova Scotia Division, its thirteen Branches and many thousands of individual members and supporters present this submission (Estimated at over 25,000 in 1960).



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CONCLUSIONS AND RECOMMENDATIONS

1. Any attempt to set up a mental health program for Canadians should have a community orientation and be concerned with the following kinds of services:-

Preventive services

Diagnostic services

Treatment services

Rehabilitation services

Consultation services to agencies

Public Education

2. In developing these services, particular attention should be paid to the concept of regional development, taking into consideration the geographic and demographic characteristics of areas.

3. In order to develop proper facilities and resources personnel is the most important thing. Therefore it will be necessary to devote more attention to recruiting, training and providing a satisfactory professional experience in order to maintain personnel in Canada.

4. Future developments of treatment services should place greater emphasis upon

- small decentralized mental hospitals in close proximity to general hospitals or preferably attached to general hospitals
- psychiatric in-patient units in general hospitals
- community out-patient clinics
- rehabilitation services

Furthermore we would recommend continued provisions for private psychiatric care.

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1 The principles inherent in such a development  
2 would be as follows:-

3 (i) That treatment be available close to the  
4 patient's home so the treatment may be given  
5 with as little dislocation from family and  
6 work as possible,

7 (ii) that treatment be available to all patients  
8 early in their illness

9 (iii) if hospitalization becomes necessary it  
10 should be as brief as possible.

11 (iv) following hospitalization, there should be an  
12 active program of follow-up care and re-  
13 habilitation including necessary drugs, vo-  
14 cational rehabilitation, foster home care,  
15 family counselling, sheltered workshops,  
16 etc.

17 (v) all these treatment services should be pro-  
18 vided by the same personnel if at all possible;  
19 that is, the same personnel should have  
20 responsibility for the patient before, during  
21 and after hospitalization. Such continuity  
22 of care would have an important stabilizing  
23 effect on the patient

24 5. Careful attention should be paid to provide adequate  
25 services to the large number of "chronic" patients in  
26 our mental hospitals, making the greatest use of modern  
27 treatment methods - occupational therapy, group methods  
28 with the utilization of the techniques of psychology and  
29 social work.

30 6. That more use be made of part time psychiatric staff in





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 That treatment be available close to the  
 (i)



1 our mental hospitals.

2 7. More use be made of psychiatrists, psychologists, social  
3 workers, as consultants to social agencies and other  
4 institutions and organized bodies.

5 8. High priority should be given to the development of  
6 children's psychiatric services including child guidance  
7 clinics, school mental health services and in-patient  
8 facilities for children.

9 9. Services for the mentally retarded be greatly expanded,  
10 as we do not, at the present time have one specially  
11 trained psychiatrist or psychologist in this field in  
12 this province.

13 10. Greatly increased research facilities are needed with  
14 administrative arrangements conducive to their most  
15 productive use.

16 11. Alert and informed citizens are a pre-requisite of a  
17 good mental health program. Opportunities should be  
18 given for them to share responsibility for the planning  
19 and development of programs and services.

20 12. Treatment of the mentally ill should be included in  
21 any medical or hospital insurance program whether govern-  
22 mental or voluntary, that is, psychiatric patients should  
23 be treated in all respects as are other sick people.

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THE PROBLEM

Extent

1. Mental illness is commonly regarded as the greatest single health problem in Canada today. The debates in the House of Commons, December 5, 1960 offer testimony that our elected representatives accepted the seriousness of the problem and that a survey was in order to study the situation.

2. Records show that almost one half of all hospital beds in Canada today are occupied by some adult or child who is mentally ill. Surveys in both Canada and the United States indicate that one person in sixteen is suffering from some form of mental disorder requiring professional help. In addition to the people who go to mental hospitals, clinics or private psychiatrists it is estimated that about 30% of all the patients who go to general hospitals are suffering from mental illness and other personality disturbances or physical illnesses associated with mental illness.<sup>1</sup>

3. These figures do not take into account the tremendous amount of individual and family suffering that is an inevitable component of mental disorders, of family separation due to long term hospitalization, and of the loss to the economy of the country as a result of such hospitalization. The actual loss to the economy of the country as a result of such hospitalization. The actual loss in manpower as a result of minor mental disturbances is not accurately calculable although informed guesses place the annual loss in one year as a result of all mental disorders at approximately \$750,000,000.00.

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1 Facilities and Personnel

2 4. One of the great concerns of the Nova Scotia  
3 Division of The Canadian Mental Health Association over the  
4 years has been the overcrowding of our mental hospitals  
5 throughout the country and the great shortage of qualified  
6 staff. This has been well documented over the past few  
7 years by D.B.S. reports and we are pleased to note that  
8 overcrowding, at least, has decreased to some extent. In  
9 Nova Scotia it is gratifying to note that most of our  
10 institutions are not operating beyond their rated bed  
11 capacity.

12 5. The thing that greatly disturbs us, and indeed  
13 should disturb all Canadian, is the low cost of care being  
14 provided in our mental hospitals. According to a memoran-  
15 dum of the Department of National Health and Welfare the  
16 cost of operating all mental hospitals (1958) was given as  
17 \$3.58 per patient per day as against \$17.24 per day for the  
18 general hospital.<sup>2</sup> These figures of course are average but  
19 even so comparisons surely indicate that our mental  
20 hospitals, by and large, are not given the same opportunities  
21 as general hospitals. The spread between the two is even  
22 greater when we consider that the general hospital cost does  
23 not include the total cost of medical care as is the case in  
24 mental hospitals.

25 6. In Nova Scotia, due to the leadership of the  
26 Mental Health Division of the Department of Health the  
27 situation is better than in many parts of Canada. Insofar  
28 as government hospitals are concerned the Nova Scotia  
29 Hospital compares favourably with the best. It is our  
30 understanding that the per diem rate is presently about



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In Nova Scotia, due to the leadership of the

mental health division of the Department of Health the

situation is better than in many parts of Canada. Indeed

our government hospitals are concerned the Nova Scotia

hospital compares favourably with the best. It is our

recommendation that the per diem rate is presently about



1 \$14.00, with the hospital caring for approximately 500  
2 patients.

3 7. The staff situation at this hospital has  
4 improved considerably since 1958 and it is probably will  
5 approach the American Psychiatric Association standards  
6 more closely than most government hospitals. However, it  
7 is a well known fact that these standards are not high  
8 enough and when drawn up were a compromise between what  
9 was regarded as minimum standards and what was attainable  
10 in a short time. The following reference bears further  
11 on this:-

12 "Nevertheless, it should be pointed out that  
13 the American Psychiatric Association's  
14 standards are themselves not high enough.  
15 They are "minimal" rather than "desirable"  
16 or "satisfactory" standards and even these  
17 minimal standards are far above what the  
18 average mental hospital attains."<sup>3</sup>

19 8. When one looks at the total mental hospital  
20 situation in the province there is still much to be desired.  
21 In addition to the Nova Scotia Hospital there are eight  
22 municipally operated hospitals with a patient population of  
23 approximately 2,000. None of these hospitals has a full  
24 time psychiatrist and only one employs a full time general  
25 practitioner. The rest employ a general practitioner on a  
26 part time basis. Present plans formulated call for one  
27 examination by a certified psychiatrist annually, with  
28 continuing psychiatric care carried out by the part time  
29 general practitioner in each hospital. The presumption  
30 here is that all readily treatable patients will be looked

1. \$4,000, with the hospital caring for approximately 500 patients.

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more closely than most government hospitals. However, it is a well known fact that these standards are not high enough and when drawn up were a compromise between what was regarded as minimum standards and what was attainable in a short time. The following reference bears further

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1 after at the Nova Scotia Hospital with a relatively high  
2 per diem rate and fairly adequate staff whereas the "chronic"  
3 patients will be treated in the municipal institutions with  
4 a low per diem cost (\$1.00-\$5.00) with consequent inadequate  
5 staffing. Such a situation is a contradiction of develop-  
6 ments which have occurred in the past decade where in  
7 institutions with proper staffing and treatment many such  
8 patients have been rehabilitated to become once again  
9 useful and productive citizens.<sup>4,5,6</sup>

10 9. A major development in the past 25 years has  
11 been the establishment of psychiatric units in general  
12 hospitals. For instance, according to D.B.S. figures in  
13 1959, 45% of first admissions of psychiatric patients in  
14 Canada were in general hospitals.

15 10. In Nova Scotia there are three such units -  
16 the Victoria General Hospital - 24 beds, Camp Hill Hospital -  
17 28 beds, and St. Martha's Hospital - 10 beds. Units are  
18 currently being organized at the Halifax Infirmary and at  
19 the Canadian Forces Hospital, Stadacona. With the exception  
20 of Camp Hill Hospital none of these units has an occupational  
21 therapist and other para-medical staff is at a minimum.  
22 Day and night hospitals are non-existent in Nova Scotia.

23 11. There are eight psychiatric clinics in Nova  
24 Scotia, staffed generally by one psychiatrist, one psycholo-  
25 gist and one social worker. Two clinics have a complement  
26 of two psychiatrists. Recently one of these clinics was  
27 forced to close due to the resignation of the psychiatrists.  
28 We understand that most of the clinics have long waiting  
29 lists with one, the Halifax Mental Health Clinic for  
30 Children, having a waiting list of nine to twelve months.

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12. Reports from these clinics would suggest that their service load is at times staggering and they are unable to give attention to developing needed rehabilitation facilities, guidance services in schools and consultation services to social agencies.

Need for Research<sup>7</sup>

13. We are greatly concerned about the fact that research into mental illness and mental health in Canada has been lagging behind research efforts in other fields of medicine. This is a serious weakness in the mental health program of our country, for on the findings and developments of research endeavours is based the success of the treatment program and in large measure the required change in public attitudes.

14. In 1952 the United States spent about \$10 million yearly on research into mental illness. Canada spent about \$400,000. Roughly speaking we spent about 3¢ a head and the United States about twice that. In addition, the large American charitable foundations contributed heavily to research in this field, while in Canada practically no private funds have been available for this purpose.

15. By 1961 the funds for research in the United States had grown to about \$100 million - a tenfold increase. In the same time Canadian funds for mental health research had just about doubled, rising to between \$800 and \$900 thousand. Allowing for the population increase this has meant an advance from 3¢ to 5¢ a head per year. Apart from the cost of lost time, lost production and other indirect costs, Canada spends about \$360 millions on mental



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39. indirect costs, Canada spends about \$350 million on mental



1 illness annually. Thus it is putting about a quarter of  
2 1% of total expenditures into research. This compares  
3 with about 1% of total expenditures which are marked for  
4 research in other fields of medicine and surgery.

5 16. In Canada about the only sizeable private  
6 fund for mental health research is that established by  
7 the Canadian Mental Health Association. During the last  
8 three years a little less than \$25,000 per annum has been  
9 collected publicly for the "National Mental Health  
10 Research Fund". A few thousand more have been made avail-  
11 able for local research projects through the provincial  
12 Divisions of the Association.

13 17. The National Mental Health Research Fund was  
14 established by the Association after careful and critical  
15 review of the policies in effect governing the allocation  
16 of federal funds through the national Mental Health Grants  
17 for research. It was noted that these funds, for the  
18 most part, are used to finance specific research projects  
19 on a relatively short term basis. It was felt that what  
20 was needed in addition to this type of research support  
21 was a fund to support researchers - scientists who could  
22 be relieved by means of a research grant from routine  
23 duties so that their full time and their career could be  
24 devoted to research planning, development and implementa-  
25 tion.

26 18. Consequently each year the total amount avail-  
27 able in the National Mental Health Research Fund is  
28 earmarked for the support of a single researcher, who  
29 thereby is given assured financial backing for a period of  
30 three to four years. The selection of a successful candidate







1 is made on the basis of evident research skill as well  
2 as the scientific field in which he is working.

3 19. This fund, therefore, is in fact a pilot  
4 project in research funding endeavouring to demonstrate  
5 to government the enormous importance of flexibility and  
6 freedom in the use of research money as well as the  
7 urgency of providing for what is in fact research fellow-  
8 ships, professorships and so on.

9 Hospital Insurance

10 20. The Hospital Insurance and Diagnostic Services  
11 Act 1957 has been successful in providing protection for  
12 most Canadians against the costs of hospital care. We  
13 regard it as one of the major advances that has been made  
14 in Canada's health services. At the same time we point  
15 out a serious defect in the Act in that it specifically  
16 excludes coverage for psychiatric illnesses treated in  
17 provincial and municipal mental hospitals, though it covers  
18 the same illnesses treated in psychiatric units of general  
19 hospitals.

20 21. Though it has been argued that these hospitals  
21 do not require coverage as they are free to the patient  
22 anyway, such is not universally true. There are provinces  
23 where individuals confined to mental hospitals are  
24 assessed a per diem rate and even though payment may not be  
25 immediately pressed it remains as a charge against them to  
26 be recovered if possible. In Nova Scotia free treatment  
27 is provided at the Nova Scotia Hospital but a charge is  
28 made in the municipal hospitals and efforts made to collect  
29 same.

30 22. In addition, exclusion places another burden





1 upon the patient in a mental hospital. Though certainly  
2 not intended to do so, it conveys an attitude that other  
3 serious long-term illnesses are more acceptable than  
4 mental illness.

5 23. This enhances some generally unfavourable  
6 attitudes regarding mental illness held by the general  
7 public, which are projected toward the mental hospital  
8 itself. This in turn has many ramifications, such as in-  
9 creasing the reluctance of the mentally ill to seek treat-  
10 ment when it would be most effective, and the discouraging  
11 of young people from entering careers in the mental health  
12 professions.

13 24. Exclusion from the Hospital Insurance Act  
14 also continues the financial difficulty which has plagued  
15 our mental hospitals through their history. Their funds  
16 have depended almost entirely upon provincial treasury  
17 opinions about the proportion of tax funds which should be  
18 assigned for mental hospital operations, with little or  
19 no consideration of the services needed for the treatment  
20 of individual patients. This results in overcrowding,  
21 obsolete facilities, underpaid and inadequately trained  
22 staffs. In Canada only one or two provincial mental  
23 hospitals have been established with a standard of service  
24 comparable to a general hospital serving the same number  
25 of patients.

26 25. As long as the present Act excludes mental  
27 hospitals, it is our opinion that they, the patients and  
28 the staff, tend to remain isolated in very sense from the  
29 total hospital system to the detriment of the patient and  
30 the community.







26. In addition to the Act most prepaid voluntary hospital and medical services insurance plans limit treatment of mental illnesses and excludes treatment in a mental hospital. Such a situation has the same effect as the Act, that of discriminating against the mentally ill. In summary we would recommend that psychiatric patients be treated in all respects as sick people including provision for medical care and hospitalization.



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1 BASIC PRINCIPLES UNDERLYING CONCLUSIONS AND  
2 RECOMMENDATIONS

3  
4 Community Orientation

5 1. Developments in psychiatry and mental health  
6 in recent years have witnessed a shift from exclusive  
7 preoccupation with isolated in-patient services to the  
8 development of treatment services located in the community.  
9 These developments have occurred as a result of both an  
10 increasing concern with rehabilitation and also the  
11 recognition of the importance of the patients' life situa-  
12 tion and social environment in mental illness.

13 2. In this view, the in-patient mental hospital  
14 services are seen as one aspect of community mental health  
15 services. If we are to get anywhere in combating mental  
16 illness successfully the mental health program, community  
17 oriented, must embody preventive, diagnostic, rehabilita-  
18 tive and consultative services as well as public education.  
19 This includes private and public psychiatric facilities  
20 in accordance with the patients' needs and resources.

21 3. It is hoped that future developments will see  
22 a shift in emphasis from the isolated mental hospital to  
23 community services where a large proportion of psychological  
24 disorders can be diagnosed and treated without hospitaliza-  
25 tion. The mental hospital would then be looked upon as  
26 one rather specialized service in the total community  
27 program.

28 4. This kind of program naturally raises questions  
29 concerning the administrative and functional relationship  
30 between the mental hospitals and the other public and



RECOMMENDATIONS

Community Orientation

1. Development in psychiatry and mental health in recent years have witnessed a shift from exclusive preoccupation with isolated in-patient services to the development of treatment services located in the community. These developments have occurred as a result of both an increasing concern with rehabilitation and also the recognition of the importance of the patient's life situation and social environment in mental illness.

2. In this view, the in-patient mental hospital services are seen as one aspect of community mental health services. It is not to get anywhere in treating mental illness necessarily the mental health program, community oriented, must embody preventive, diagnostic, rehabilitative and consultative services as well as public education. This includes private and public psychiatric facilities in accordance with the patient's needs and resources.

3. It is hoped that future developments will see a shift in emphasis from the isolated mental hospital to community services where a large proportion of psychological disorders can be diagnosed and treated without hospitalization. The mental hospital would then be looked upon as a rather specialized service in the total community.



1 private community services. This is particularly true in  
2 Nova Scotia where the Nova Scotia Hospital is provincially  
3 operated and where most of the mental health clinics  
4 involve citizen responsibility.

5 5. should be It should be possible however to achieve  
6 functional integration of all these services with a high  
7 degree of co-operation.

#### 8 Regionalization

9 6. One of the basic premises of Canadian Mental  
10 Health Association Scientific Planning Committees has  
11 been that mental health services should be developed on  
12 the basis of regional planning. That is, community mental  
13 health services should be planned with reference to natural  
14 demographic and geographic areas within the province so  
15 as to provide facilities accessible to the population of  
16 the region. The situation in Nova Scotia, so far as  
17 clinic treatment facilities are concerned, meets this principle  
18 with the exception of three areas which are to have clinics  
19 when personnel is available.

20 7. So far as active treatment hospitals are  
21 concerned the Nova Scotia Hospital is still the only  
22 hospital of this type. The situation is such, however, that  
23 if funds and staff were available we could have all our  
24 county hospitals turned into active treatment centres  
25 rather than remain largely as custodial hospitals for the  
26 chronically mentally ill.

27 8. Shortages of mental health personnel in most  
28 mental hospitals is noted in Canada today. When one  
29 examines the personnel situation across Canada and the  
30 United States it is alarming to find in 1959 that in our





private community services. This is particularly true in Nova Scotia where the Nova Scotia Hospital is provisionally operated and where most of the mental health clinics

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concerned the Nova Scotia Hospital is still the only

hospital of this type. The situation is such, however, that

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rather than remain largely as custodial hospitals for the

mentally ill.

Shortages of mental health personnel in most

mental health units is noted in Canada today. When one

examines the personnel situation across Canada and the

various factors it is a surprise to find in 1959 that in one



1 Canadian mental hospitals there was one physician for  
2 every 137 patients and one psychiatrist for each 359  
3 patients.<sup>8</sup> In Nova Scotia there was one physician for  
4 each 112 patients and one psychiatrist for each 855 patients.  
5 It should be added that since 1959 there has been  
6 considerable improvement in the staff situation. In the  
7 Nova Scotia Hospital there are now 13 physicians who have  
8 had some post-graduate training in psychiatry bringing  
9 the ratio down to one such physician for 183 patients.  
10 However, since this staff is centred at the Nova Scotia  
11 Hospital for 500 patients it leaves psychiatric care  
12 available to the 2,000 patients in the municipal hospitals  
13 limited to one psychiatric examination per year.

14 9. In view of the above, every effort should be  
15 made in the recruitment of personnel for training, the  
16 further development of all training facilities, and a  
17 concerted effort made to maintain our personnel in Canada  
18 by providing satisfactory professional careers.

19 10. In developing treatment services greater  
20 emphasis should be placed upon

21 a) small mental hospitals in close proximity to  
22 general hospitals or preferably attached to  
23 general hospitals.

24 b) psychiatric units in general hospitals

25 c) community clinics

26 d) rehabilitation services

27 Furthermore we would recommend continued provision for  
28 private psychiatric care.

29 11. As mentioned above, Nova Scotia is in a  
30 fortunate position of having already established small



Canadian mental hospitals there was one physician for every 137 patients and one psychiatrist for each 399 patients. In Nova Scotia there was one physician for each 115 patients and one psychiatrist for each 355 patients. It should be noted that since 1959 there has been considerable improvement in the staff situation. In the Nova Scotia Hospital there are now 13 physicians who had some post-graduate training in psychiatry bringing the ratio down to one such physician for 133 patients. However, since this staff is centred at the Nova Scotia Hospital for 500 patients it leaves psychiatric care available to the 2,000 patients in the municipal hospitals started to one psychiatric examination per year. In view of the above, every effort should be made in the recruitment of personnel for training, the further development of all training facilities, and a concerted effort made to maintain our personnel in Canada by providing satisfactory professional careers.

In developing treatment services greater emphasis should be placed upon:

- (a) small mental hospitals in close proximity to general hospitals or preferably attached to general hospitals.
- (b) psychiatric units in general hospitals.

Furthermore we would recommend continued provision for psychiatric care.





1 regional mental hospitals which, if properly developed,  
2 provide an excellent opportunity for hospital treatment  
3 services.

4 12. The psychiatric units in general hospitals  
5 would bring earlier treatment services closer to the community  
6 with less social and personal dislocation. Such services  
7 in many cases would result in a shortening of the patient's  
8 illness.

9 13. The same argument holds true for the community  
10 mental health clinics. In Nova Scotia we are more  
11 fortunate perhaps than the rest of Canada in having most  
12 of the province covered by mental health clinics, the  
13 only drawback being the shortage of personnel to carry  
14 out an effective comprehensive program in all areas of  
15 which we see treatment as only one aspect.

16 14. Careful attention should be paid to provide  
17 adequate services to the large number of "chronic" patients  
18 in our mental hospitals. In Nova Scotia our services for  
19 these patients are disgracefully inadequate. For the most  
20 part these 2,000 patients receive one psychiatric examina-  
21 tion yearly and continuing care provided by general  
22 practitioners on a part time basis. For these 2,000  
23 patients there are no social workers, psychologists, nor  
24 qualified occupational therapists to carry out recreational  
25 and rehabilitative procedures. Experience elsewhere  
26 indicates that a number of these patients could be  
27 returned to society if these and other services could be  
28 available.<sup>5,6</sup> With adequate staffing these institutions  
29 could develop more "open" wards and generally enhance the  
30 therapeutic climate and thus cut down on the needless waste





1 of human lives let alone waste of public funds.

2 15. Rehabilitation and rehabilitative measures  
3 must at all times be a pre-requisite of adequate care,  
4 particularly for the "chronic" mentally ill mentioned  
5 above. The provision of after-care services, foster  
6 homes, sheltered workshops, half-way houses, day care and  
7 night care units in hospitals should be explored and  
8 developed. These services are seen as necessary in any  
9 comprehensive program for the "chronic" mental patients and  
10 the acutely disturbed and no doubt would result in getting  
11 more patients out of hospital as well as cutting down on  
12 the length of hospital stay. The concept of foster home  
13 care, sheltered workshops, halfway houses and therapeutic  
14 clubs recognizes that the community made up of a vast  
15 number of interested, talented and knowledgeable citizens  
16 with proper direction can make a significant contribution.  
17 The use of these people and resources also helps to break  
18 down the isolation of the mental hospital and accordingly  
19 the patients' feeling of isolation and hopelessness  
20 while in hospital.<sup>9,10,11</sup>

21 16. Careful attention should be given to the  
22 employment of part-time psychiatric staff in our mental  
23 hospitals. This would be seen as a means of making the  
24 hospital and its treatment services more community centred  
25 by providing opportunity for psychiatric personnel to do  
26 community work as well as hospital work. They would thus  
27 be engaged in coping with the entire range of psychiatric  
28 problems. Their hospital treatment, as a result of their  
29 community experiences would, it is felt, be more effective.

30 "Public psychiatry must begin in the community,







1 must pass through hospitals, and return again  
2 to the community. The professional staff  
3 must be given the opportunity to work along  
4 this line, seeing and treating patients at  
5 every step."<sup>12</sup>

6 17. For the same reason attention should be given  
7 to the employment of psychiatrists who are presently not  
8 on hospital staff but engaged in private practice in their  
9 communities. The latter group would necessarily be able  
10 to follow their own patients through private psychotherapy  
11 and subsequently continue this if it became necessary to  
12 hospitalize the patient. Apart from the therapeutic  
13 advantages of such a system of care it is felt by many  
14 persons in psychiatry that such a development could result  
15 in improving the staff situation due to careers being more  
16 interesting.

17 18. In recommending continued provision of private  
18 psychiatric care it is recognized that tax supported  
19 hospitals and medical services insurance plans provide  
20 only minimum care. The opportunity to carry on private  
21 practice would also provide more incentive for psychiatrists  
22 to remain in the field.

23 19. More use should be made of psychiatric trained  
24 staff, that is, psychiatrists, psychologists, social  
25 workers, as consultants to social agencies and other  
26 institutions dealing with problems which in part may be  
27 psychological. It is recognized that many of these agencies  
28 are handling these problems already without the benefit of  
29 psychiatric consultation. In our opinion there has been an  
30 increasing demand for these services but the shortage of



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1 personnel makes it impossible to fill these demands,  
2 adequately.

3 20. High priority should be given to children's  
4 psychiatric services, including child guidance clinics,  
5 school mental health services and in-patient facilities  
6 for children. When one looks at the Nova Scotia situation  
7 such services are sadly lacking despite the great need for  
8 them. It is felt that by focusing more and more attention  
9 on children, who constitute the bulk of our population,  
10 that many mental disorders may possibly be corrected at  
11 an early age thus cutting down on the prevalence of the  
12 more serious disorders in later life.

13 21. More emphasis should be placed on research. As  
14 yet our knowledge regarding mental disorders is completely  
15 inadequate. A sound research attack on problems of mental  
16 illness and mental health can be mounted on no other base  
17 than a long term one. The prospect of a crash program  
18 and a quick breakthrough is not realistic in the absence  
19 of a vast increase in basic knowledge. Every effort  
20 should be made to secure personnel from many disciplines,  
21 that is psychiatry, psychology, bio-chemistry, sociology  
22 and others so that a diversified attack can be made on the  
23 problem. While we are not prepared to flatly state the  
24 amount of money that should be spent on research annually  
25 we are greatly concerned about how little is spent in  
26 Canada compared with the cost of caring for the mentally  
27 ill.

28 22. One principle we would like to recommend here  
29 so far as the use of federal mental health grants for  
30 research is concerned is that these not be limited to



Statement of Dr. James H. Heston, Director, National Institute of Mental Health

March 1, 1967

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22. One principle we would like to recommend here is that as the use of federal mental health grants for research is concerned is that these not be limited to



1 conducting research on a yearly basis. The important  
2 thing is to secure personnel who are interested in making  
3 a career type of research. Such a limitation mitigates  
4 against the career type of research. In this connection  
5 also we would recommend that research funds be set up as  
6 a separate entity thus avoiding the necessity of competing  
7 with service requirements for sadly inadequate funds.

8 23. Alert and informed citizens are a pre-  
9 requisite of a good mental health program. They are needed  
10 to share responsibility for the planning and development  
11 of programs and services. The argument here is that  
12 whereas the focus is on community services of all types  
13 the organization and operation, as much as possible, should  
14 be carried by the citizens of the community. The pro-  
15 fessional practitioner naturally shares his appropriate  
16 responsibility. The following reference bears further  
17 on this:-

18 "It is most unsound for "experts" to assume  
19 exclusive responsibility for planning any  
20 public program including mental health.

21 Community participation is essential for unless  
22 the community actually assumes responsibility  
23 for the program the resources to carry it out  
24 will not be made available and the actual  
25 needs of people are apt not to be met.

26 Citizens are too often brought into programs  
27 after they have already been planned. This  
28 makes the motives of the professional worker  
29 and is not really wanted as a collaborator and  
30 partner. On the other hand, most citizens are





thing is to secure personnel who are interested in making  
a career type of research. Such a limitation might be  
against the career type of research. In this connection  
also we would recommend that research funds be set up as  
a separate entity thus avoiding the necessity of competing  
with service requirements for such inadequate funds  
Alert and informed citizens are a pre-  
requisite of a good mental health program. They are needed  
to share responsibility for the planning and development  
of programs and services. The argument here is that  
whereas the focus is on community services of all types  
the organization and operation, as much as possible, should  
be carried by the citizens of the community. The pro-  
fessional practitioner naturally shares his appropriate  
responsibility. The following reference bears further

on this:-

'It is most unusual for "experts" to assume  
exclusive responsibility for planning any  
public program including mental health.  
Community participation is essential for success.  
The community actually assumes responsibility  
for the program and resources to carry it out.  
Will not be made available and the social  
needs of people are apt not to be met.  
Citizens are too often brought into programs  
after they have already been planned. This  
makes the motives of the professional worker  
and is not really wanted as a collaborator and  
partner. On the other hand, most citizens are



1 not in a position to decide alone how they  
2 can best further the mental health of the  
3 community. They have need for the help that  
4 specialists can give them. Respect for each  
5 other's contribution will develop not only a  
6 better community mental health program but  
7 a better society."13

8 PRIORITIES

9 The greatest priority in the mental health  
10 field today we would regard is PERSONNEL. While we regard  
11 the above recommendations as essential in establishing a  
12 comprehensive mental health program there must at all times  
13 be adequate professionally trained personnel to execute  
14 this program. Emphasis must be placed on developing  
15 adequate training facilities so that personnel will be  
16 available to staff the many facilities, services, and  
17 programmes in the mental health field.

18 Respectfully submitted on behalf of  
19 Nova Scotia Division, The Canadian Mental  
20 Health Association

21 Rev. D.F. Campbell, President

22 M.R. Rankin, Vice-President

23 Aubrey Shane, M.D., Chairman, Scientific  
24 Planning Committee

25 Solomon Hirsch, M.D. Board Member

26 Andrew Crook, Executive Director

27 J.D. Griffin, M.D., General Director  
28  
29  
30







REFERENCES

1. "Facts and figures about mental illness and other personality disturbances", National Association for Mental Health, Inc. New York, 1952
2. Hospital Care in Canada, Health Care Series Memo No. 12 Research and Statistics Division, Dept. of National Health and Welfare, Ottawa, March 1960
3. Humane Institutions, Annual Report, Province of Nova Scotia 1957
4. From Custodian to Therapeutic Patient Care in Mental Hospitals by Milton Greenblat, Richard H. York, and Esther Lucile Brown, Russell Sage Foundation, New York, 1955
5. Remotivating the Mental Patient by Otto von Mering, and Stanley H. King, Russell Sage Foundation, New York, 1957
6. Care and Treatment of the Hospitalized Mentally Ill by Walter E. Barton, M.D., Mental Hygiene, National Association for Mental Health, New York, April 1960
7. A New Fund for Research Careers in Mental Health, Canadian Mental Health Association. Copies available on demand.
8. Mental Health Statistics 1959, Dominion Bureau of Statistics
9. Development of a Comprehensive Psychiatric Community Service Around the Mental Hospital, by Bertram Mandelbrote, M.D., D.P.M., Mental Hygiene, July 1959
10. The Rehabilitation and Disposition of Chronically Hospitalized Schizophrenic Patients, Mental Hygiene, July 1958



Development of a Comprehensive Psychiatric Community  
Service Around the Mental Hospital, by Bertram  
Mandelbrove, M.D., D.P.M., Mental Hygiene, July 1959

The Identification and Disposition of Chronic  
Mental Patients, by Bertram

Mental Health Statistics 1959, Dominion Bureau of  
Statistics, Ottawa, 1960

A New Fund for Research Centers in Mental Health,  
Canadian Mental Health Association, Copies available  
on demand.

Care and Treatment of the Hospitalized Mentally Ill  
by Stanley H. King, Russell Sage Foundation, New  
York, 1957

Remotivating the Mental Patient by Otto von Meining,  
New York, 1955

and Esther Lucile Brown, Russell Sage Foundation,  
Hospitals by Milton Greenblatt, Richard H. York,  
From Custodian to Therapeutic Patient Care in Mental  
Hospitals 1957

Humane Institutions, Annual Report, Province of Nova  
Scotia, March 1959

No. 12 Research and Statistics Division, Dept. of  
Hospital Care in Canada, Health Care Series Memo  
for Mental Health, Inc. New York, 1958

Psychiatric and Physical Mental Illness and  
Other



- 1 11. After Care Services for the Mental Hospital Patient,  
2 Mental Hygiene, July 1960
- 3 12. The New public Psychiatry, by George H. Preston in  
4 Mental Hygiene, April 1957
- 5 13. Integrating Mental Health Services Into the Community  
6 Health and Welfard Programme, Warren C. Lamson in J.  
7 Psychiatric Social Work, September 1955.





After Care Services for the Mental Hospital Patients

Mental Hygiene, July 1960

The New Public Psychiatry, by George H. Fenton in

THE JOURNAL OF THE ROYAL SOCIETY OF MEDICINE

Integrating Mental Health Services into the Community

Health and Welfare Programs, Warren C. Larson in J.

THE JOURNAL OF THE ROYAL SOCIETY OF MEDICINE



1 THE CHAIRMAN: Thank you, Dr. Shane.

2 COMMISSIONER VAN WART: Is it your concep-  
3 tion that the so-called mental hospitals at the present  
4 time be brought in under the scheme -- under any proposed  
5 scheme of insurance?

6 DR. SHANE: Yes.

7 THE CHAIRMAN: That would come about, I  
8 take it, through an expansion of the present hospitaliza-  
9 tion program; is that what you mean?

10 DR. SHANE: Possibly Dr. Jones might answer  
11 that.

12 DR. JONES: Mr. Chairman, I think the vital  
13 point in the brief is No. 12, which suggests that mental  
14 illness should be treated -- that is, should get medical  
15 services and should get hospital services in exactly the  
16 same way that people suffering from other forms of illness  
17 do. One must realize this carries with it certain diffi-  
18 culties. The main difficulty is the question of chronicity,  
19 and we would suggest that rather than thinking about mental  
20 and physical illness, one should think about acute, semi-  
21 acute and chronic illness, and that there is a huge bulk  
22 of chronic illness in the country from which the mental  
23 and chronically ill should not necessarily be separated.  
24 We do not believe this problem of chronicity of mental  
25 illness need be as great a problem as it is, and there  
26 are a great many studies which would suggest that with  
27 proper and adequate treatment early, with the provision  
28 of some sort of brief hospitalization that would not be  
29 a sign to keep people ill as some of our hospitals currently  
30 are, and with an active rehabilitation program, that over



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1 the years we would see a very great reduction in the amount  
2 of chronic illness. That, as I am sure you are all aware,  
3 has happened to some extent. Most of the mental hospitals  
4 on this continent are reporting a lessening patient popula-  
5 tion than they had 10 years ago, but we believe only a  
6 start has been made in this.

7                   Therefore, we think if the psychiatric  
8 patient were treated in just the same way, had medical  
9 and hospital facilities freely available to him -- and  
10 here we would like to point out that in other areas of  
11 medicine the private facilities are open to the patient  
12 and we believe private facilities should be open to psychia-  
13 tric patients as well -- if this were the case, and if  
14 every community of reasonable size had its own psychiatrist  
15 who was part of that community, then people would go to  
16 that doctor early. They would keep going to him in  
17 moments of crisis as they do to private practitioners in  
18 Halifax at the moment, and we think this is a very impor-  
19 tant provision in the mental health of this country, and  
20 I hesitate to say this, but I think in the long run we  
21 may very well cut down in the mass of expenditures if we  
22 had this sort of active program.

23                   THE CHAIRMAN: Thank you. You speak of  
24 early detection: can you deal with that in the same way  
25 as you do with the detection of other illness?

26                   DR. JONES: There are obvious difficulties.  
27 There is the whole problem of stigma and so on. Having  
28 been in this Province for 20 years, and having seen some  
29 considerable changes in that time, I think one can say  
30 that this is very markedly lessening. We in this Province

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29 considerable changes in that time, I think one can say

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1 have had an active program of education for public health  
2 nurses-- the public who go into the homes often when a  
3 baby is born and follow that family throughout their life,  
4 and we believe the public health nurse is a very important  
5 person in helping a family to recognize early mental  
6 illness. We believe the same thing is true of the school-  
7 teacher. We are trying to help people in all these fields  
8 to be alert for this kind of thing. The Society generally  
9 is doing its best to try to remove a good deal of the  
10 stigma, and I think the fact that 20 years ago, when I  
11 came to this City, it was said that a private psychiatrist  
12 could not make a living in it and now there are eight  
13 making very good livings is an indication of our success  
14 in that field.

15 COMMISSIONER BALTZAN: When you speak of  
16 the decentralization which is the modern trend, when these  
17 people become patients in a hospital, or are attached to  
18 a hospital, they would then be like those on physical  
19 medicine -- in a ward known as a psychiatric ward?





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dpw

1 DR. JONES: Well, as I remarked yesterday,  
2 sir, the facts are that about 40% of the psychiatric  
3 admissions in Canada now go to general wards in hospitals.  
4 I think that all of us would support this as a very useful  
5 and proper correction of affairs. We do have to recognize  
6 that we can't always treat patients as long as we would  
7 like in the general hospitals. We do feel there is a need  
8 for regional hospitals closely associated with the general  
9 hospital in that region, sharing the same staff, and so  
10 on.

11 COMMISSIONER BALTZAN: But it is true of  
12 the majority, speaking of the psychiatrics, those people  
13 who could be assisted quickly and relieved much more  
14 quickly than the form of transitory treatment very early  
15 in a general hospital?

16 DR. JONES: I can only say yes to that.

17 COMMISSIONER GIRARD: I appreciate the fact  
18 that public health nurses were very helpful in helping  
19 to detect cases in psychiatry. I would like to know if  
20 all the schools of nursing require psychiatric affiliation  
21 of their students before they graduate.

22 DR. JONES: I am sure that the presenters  
23 of the following brief will be able to answer that much  
24 more accurately than I can. I don't want to say something  
25 that is not correct on the record. Certainly the majority  
26 of them do. As you know, most of the registry bodies in  
27 the United States do, and we have had pressure in this  
28 country for nurses to have psychiatric training.

29 COMMISSIONER FIRESTONE: Mr. Chairman, my  
30 first question is addressed to Father Campbell. Father,



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1 this is a very comprehensive and useful brief. It  
2 suggests that the Nova Scotia Division of the Canadian  
3 Mental Health Association and everyone associated with  
4 the field of mental health have made good progress in  
5 Nova Scotia, and then you have come forward with a number  
6 of recommendations how progress could be speeded up and  
7 how things could be improved in the future. Could we  
8 have from your Association a supplementary submission  
9 presented to us as to what this comprehensive program and  
10 all the recommendations you are making would cost and  
11 where the money would come from for such a program? We  
12 realize we are getting a brief from your main body, but  
13 we are interested in the views in each Province, and we  
14 would be pleased to receive a supplementary brief from  
15 you.

16 REV. CAMPBELL: Mr. Chairman, we would be  
17 very happy to do so. We found from listening to your  
18 questions this morning that we hadn't anticipated all the  
19 questions you would ask. However, we did give this some  
20 consideration. But some members might have some estimates  
21 to make at the moment. However, these would be approxima-  
22 tions. I am sure some of them had this in their mind.  
23 Would you even entertain a calculated guess, or would you  
24 prefer a more precise estimate?

25 COMMISSIONER FIRESTONE: We are very  
26 interested in what you have to say, whatever additional  
27 information you have to give, we would appreciate the  
28 views of your Association at a later point, but any views  
29 you have at the moment would be welcome.

30 DR. JONES: In connection with the Canadian



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1 Medical Association, I am afraid that estimates in the  
2 field of mental health are probably the most difficult  
3 things to produce. That has been well spelled out in the  
4 book "Economics of Mental Illness". We feel that at the  
5 present moment, to have our present services operate at  
6 reasonable efficiency we should spend at least a million-  
7 and-a-half dollars in addition to what we are currently  
8 spending, and we feel there will be future developments  
9 which will be rather costly. We will try to put something  
10 down about that. I would wish to reiterate that all our  
11 problems are not in the field of finances; many of them  
12 are in the field of personnel, and we, in our Department  
13 this year, will probably have to turn down applicants for  
14 training who will probably make good psychiatrists because  
15 we don't have the facilities for training. Secondly, we  
16 do feel that the problem is so big that public finances  
17 can never meet it adequately and we do have to have some  
18 joint system where the people who have to have this treat-  
19 ment in this field can pay for it instead of being denied  
20 it as they are in our institutions at the moment.

21 COMMISSIONER FIRESTONE: You made two very  
22 good points. One was that you needed professionally  
23 trained people. We would hope that your supplementary  
24 submission would tell us what would be involved to create  
25 these expanded training facilities, and I presume it won't  
26 hurt the establishment and financing of those establish-  
27 ments to have financial help, and we would like to know  
28 what those are.

29 The second point you made was that people  
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1 contribute. Presumably that would be included in your  
2 submission when you speak about where the money is coming  
3 from for the expanded services. Could we therefore leave  
4 that to a later date?

5 REV. CAMPBELL: Yes.

6 COMMISSIONER FIRESTONE: If that is the case,  
7 I would like to pursue one further submission. If I may  
8 pursue the question at the moment of the economics of  
9 health rather than the economics of ill-health, although  
10 they are two sides of the same coin. We would like to  
11 have a little bit of advice from some of the professional  
12 members of the team, Father Campbell, on what is really  
13 involved as far as economic losses are concerned due to  
14 ill health, and I am referring now to mental ill-health.

15 On page 4 of your submission, Part II, you  
16 speak in paragraph 3, and I quote: "The actual loss in  
17 manpower as a result of minor mental disturbances is not  
18 accurately calculable although informed guesses place the  
19 annual loss in one year as a result of all mental  
20 disorders at approximately \$750,000,000". Can you tell us,  
21 first of all, what this estimate means? Is this estimate  
22 a reflection of the loss of production due to the inability  
23 to work and/or due to reduced efficiency?

24 REV. CAMPBELL: Dr. Jones I believe can  
25 handle that. My impression is that this again is a calcu-  
26 lated guess. The reference is not given, but I think it  
27 is from the Joint Commission on Mental Illness, one of  
28 their reports.

29 DR. JONES: I believe sir, it is from one  
30 of the national publications. I certainly have not any



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1 approximation of the Nova Scotia situation. However, it is  
2 a point that did concern Dr. Klein very greatly, and he  
3 sets out certain tables in his book, for calculating the  
4 indirect cost, and it would be comparatively simply to  
5 apply that to our own population.

6 COMMISSIONER FIRESTONE: Could you elaborate  
7 a little further and rely on ~~your~~ experience in this field?  
8 What happens to the mentally ill or people who have some  
9 mental disorders as far as their ability to produce is  
10 concerned? I am not referring to those in institutions  
11 or hospitals; obviously they are not available to produce,  
12 but those who are at home where the man is working or the  
13 woman is employed. How does mental health affect the  
14 ability to work? Does it mean that they are off for  
15 several days? Does it mean they are going to be laid off  
16 because they are not any good? What does it mean in terms  
17 of economic losses due to mental ill health?

18 DR. JONES: I can't agree with the phrase  
19 which suggests that a hard-working man is a mentally ill  
20 man. I do not believe that one can make a blanket state-  
21 ment about mental illness and say that it does this or  
22 that to a person's ability to work, their productiveness,  
23 and so on. There are some forms of mental illness that  
24 certainly cut down very markedly in a person utilizing  
25 his full resources, and I am afraid that is the most  
26 common form, and in a patient who is mentally ill we do  
27 lose some years of their life as far as their productive  
28 capacity is concerned. I think the most important question  
29 is that at the Victorian General Hospital we had 4 patients  
30 who came in because they are depressed, and they all



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1 received electro-convulsive treatment. They were to  
2 receive their treatment this morning; they will return  
3 to work this afternoon. Three will be returning on  
4 Saturday, and I think will do a reasonable job, and the  
5 other man, who is pretty well at the end of his treatment,  
6 will do very well working.

7 COMMISSIONER FIRESTONE: I presume, then,  
8 that if you in the Province of Nova Scotia embarked on an  
9 extensive program involving mental health it would improve  
10 the people's ability to earn an income, and the cost in  
11 improving mental health would be only a small fraction in  
12 comparison with the gain. And that was going to lead to  
13 the last question, because I was going to suggest it may  
14 be difficult for the Nova Scotia Chapter to prove this  
15 point, but I just wondered whether you would wish to pass  
16 this matter on to your parent organization for recommenda-  
17 tions for increasing the program, the expenditures involved,  
18 if this can be justified not only in human terms but also  
19 in economic terms. Thank you very much.

20 THE CHAIRMAN: There is one question I  
21 would like to put to Father Campbell, which I have put to  
22 a number of other voluntary organizations, and that is  
23 could we have your views on the place of the voluntary  
24 organization in any comprehensive medical services program.  
25 I am not suggesting that you necessarily deal with that  
26 now, but we would like to have your considered views on  
27 the place of the voluntary organization, assuming that  
28 some program is forthcoming, what is going to happen to  
29 such an organization as yours?

30 REV. CAMPBELL: Mr. Chairman, I am not in a





1 received electro-convulsive treatment. They were to

2 to work this afternoon. There will be returning on

3 Saturday, and I think will do a reasonable job, and the

4 other man, who is pretty well at the end of his treatment,

5 will do very well working.

6 COMMISSIONER FIRMSTONE: I presume, then,

7 that if you in the Province of Nova Scotia embarked on an

8 extensive program involving mental health it would improve

9 the people's ability to earn an income, and the cost in

10 improving mental health would be only a small fraction in

11 comparison with the gain. And that was going to lead to

12 the last question, because I was going to suggest it may

13 point, but I just wondered whether you would wish to point

14 this matter on to your parent organization for recommendations

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24 now, but we would like to have your considered views on

25 the place of the voluntary organization, assuming to be

26 some program is forthcoming, what is going to happen to

27 such an organization as yours?

28 MR. CAMPBELL: Mr. Chairman, I am not in a



1 position to answer that question at the moment, but  
2 whatever the scheme that is finally devised, whatever  
3 scheme you think will protect the common good, that the  
4 people that we represent, those who are suffering from  
5 forms of mental illness receive the same consideration  
6 in the recommendation as in the case of those who suffer  
7 from other forms of mental illness. It would depend on  
8 the type of hospital scheme that is recommended. I am  
9 not sure of what type is best at the moment. However,  
10 personally again, I should expect that any recommendations  
11 made to Government would respect the right of voluntary  
12 associations to set up treatment centres and that they  
13 would be considered in any appropriations that would be  
14 given, so if a voluntary organization such as ours or any  
15 charitable organization can demonstrate its ability, I  
16 don't think it should be excluded from any form of medical  
17 recommendation that may be made. However, I think we  
18 could present something to you.

19 THE CHAIRMAN: Thank you very much.

20 MR. CROOK: Mr. Chairman and members of the  
21 Commission, I would like a chance to speak on this,  
22 because, after all, it is part of my function as I meet  
23 with the branches and establish new branches in the  
24 Province to help them realize they a very great contribu-  
25 tion to make in this field. As Father Campbell has said,  
26 it depends on what sort of comprehensive scheme we are  
27 going to bring in, whether it is going to be entirely  
28 government or allow for the participation of voluntary  
29 organizations. But I would submit that our stand - I  
30 would like to illustrate this stand perhaps a little more



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1 clearly by pointing out, of course, that in this Province  
2 today, as a result of Government co-operation with our  
3 own organization, we have, as Father Campbell pointed out,  
4 8 mental health clinics in this Province or 8 communities  
5 in which mental health clinics are established, and those  
6 established as a result of our own organization being  
7 allowed to carry on educational programs in the communities,  
8 point up the need for services in the communities, take  
9 responsibility for sponsoring medical health clinics.



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dpw 1                    Granted, most of the funds to operate these  
2 clinics come from the Government, and we are asked as a  
3 result of our annual campaigns to help support these  
4 clinics. In addition to helping establish these clinics  
5 and carrying out continual financial support of these  
6 clinics, we are also responsible directly in the admini-  
7 stration of these clinics. This means that you may have a  
8 professional providing service to patients, but as well  
9 you have a Board of Directors who are directly responsible  
10 to our organization, appointed by the medical and other  
11 important groups in the community. We feel that this  
12 accounts for the fact that in this Province we have a  
13 large amount of public involvement in our service, as well  
14 as the Government being involved largely in the financing  
15 of these clinics, and you may say it is socialized medicine  
16 to a certain extent, but it results in very good services,  
17 and I have no hesitation in recommending that this sort of  
18 thing be adopted right across the country, because we do  
19 have evidence to indicate that where you have not got this  
20 public involvement and participation and opportunity to  
21 help carry out some of the administration, that you do not  
22 get the interest that helps to keep these things going.  
23 There are many other things, but I think this best illus-  
24 trates the role of a voluntary organization in this.

25                    THE CHAIRMAN: Thank you very much.

26                    COMMISSIONER BALTZAN: I see here on page 1  
27 a number of things that you advise for orientation, and  
28 I will only refer to preventative services. Could you in  
29 the future submission proposed spell out what you mean,  
30 and what methods are used, or that you advise should be





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1 considered in the terms of prevention, and might I add  
2 another chapter, even the preservation of good mental health.

3 REV. CAMPBELL: Yes, Mr. Chairman, I under-  
4 stand that even on the definition that the experts will  
5 argue, so that we will give them an opportunity to fight  
6 it out, and then present their compromise on what they  
7 think is necessary.

8 THE CHAIRMAN: Thank you very much, Father  
9 Campbell and gentlemen, and we are obliged to you for the  
10 time you put in in preparation of the brief and for being  
11 here.

12 The next submission will be from the  
13 Registered Nurses' Association of Nova Scotia.

14 SUBMISSION OF THE REGISTERED NURSES'

15 ASSOCIATION OF NOVA SCOTIA

16 Appearances: Miss Reta Myers, President  
17 Miss E.A. Electa MacLennan  
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ASSOCIATION OF NOVA SCOTIA

Apparatus: Miss Heta Myers, President  
Miss E.A. Elceta MacIsaac





SUBMISSION OF  
THE REGISTERED NURSES' ASSOCIATION  
OF NOVA SCOTIA

Appearances:

E. A. E. MacLennan	Chairman, Committee on Pre- paration of Briefs and
	Member, Executive Committee, R.N.A.N.S.

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1. INTRODUCTION

1. The Registered Nurses' Association of Nova Scotia express their appreciation to the Royal Commission on Health Services for the opportunity of bringing to the attention of the public some of the hopes and fears of the profession concerning the provision of health services for the Canadian people now and in the foreseeable future.

2. This statement is very brief, knowing that many more documents from provincial and national nursing bodies will be reaching your desks in which will be frequent repetition of the needs of nursing which are basic to the profession and common to all geographic areas. The Registered Nurses' Association of Nova Scotia wishes to avail itself of the privilege extended in the invitation to submit additional material at subsequent hearings of the Commission.

3. It is my privilege as a member of the Executive Committee and Chairman of the Committee on



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Chairman, Committee on Pro-  
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1 Preparation of Briefs to the Royal Commission on Health  
2 Services, to present the views of the Registered  
3 Nurses' Association of Nova Scotia concerning the  
4 part our Association should play in providing to the  
5 people of Canada the best possible health service.

## 6 II. THE ASSOCIATION

7  
8 4. The Registered Nurses' Association of Nova  
9 Scotia is a professional association organized 50 years  
10 ago and incorporated under the Registered Nurses'  
11 Association of Nova Scotia Act in 1931.

12 5. Its membership is composed of qualified  
13 graduate nurses who have met the requirements of  
14 the Registered Nurses' Association of Nova Scotia.  
15 Present membership stands at 3052.

16 6. Among its powers the Association is authorized  
17 and empowered -

18 "(a) to provide for the government, dis-  
19 cipline and honour of persons practising  
20 as registered nurses within the Province  
21 of Nova Scotia;

22 (b) to establish and maintain a Register  
23 which shall be the official register of  
24 persons entitled to practise as registered  
25 nurses within the Province of Nova Scotia,  
26 and the official register of Honorary  
27 and Associate members of the Association;

28 (c) to prescribe the nature and extent of  
29 the education in nursing which must be  
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1 to practise as a registered nurse within  
2 the Province of Nova Scotia;  
3 (d) to provide facilities for determining  
4 by examination or other means, the com-  
5 petency of persons seeking to practise as  
6 registered nurses within the Province of  
7 Nova Scotia, and to grant Certificates of  
8 Registration to persons so qualified to  
9 practise."

10 (The Registered Nurses' Association  
11 of Nova Scotia Act, 1950)

12 7. The work of the Association is carried  
13 on through Committees. Some major projects which  
14 have been undertaken in the past few years include  
15 such activities as (a) developing "Requirements and  
16 Recommendations for Approved Schools of Nursing in  
17 Nova Scotia"; (b) developing personnel policies - a  
18 guide for employers; (c) a "Survey and Evaluation of  
19 Schools of Nursing for Approval"; (d) Revision of the  
20 curriculum used in schools of nursing in Nova Scotia  
21 (still under study); (e) establishing "The Registered  
22 Nurses' Association of Nova Scotia Retirement Savings  
23 Plan".

24 8. The Association endeavours to keep  
25 abreast of new developments in community health ser-  
26 vices and gives support to the many health services  
27 in the Province through representation on executive  
28 boards and committees of all the major agencies such  
29 as The Canadian Red Cross, Victorian Order of Nurses  
30 for Canada, Maririme Hospital Association, Canadian



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8. The Association endeavours to keep

abreast of new developments in community health services and gives support to the many health services in the Province through representation on executive boards and committees of all the major agencies such as The Canadian Red Cross, Victorian Order of Nurses





1 Mental Health Association, Advisory Committees to  
2 the Provincial Department of Health, Civil Defence  
3 and many others.

4 9. The Registered Nurses' Association of  
5 Nova Scotia is acutely aware of the role which nurses  
6 should play in furthering Canada's Health Program.  
7 Increasing population, expanding health services and a  
8 greater complexity of nursing functions contribute to  
9 the problem of supplying sufficient qualified per-  
10 sonnel to meet the increasing demands.

11 10. One of the main objectives in any health  
12 plan is to provide "adequate nursing service". To  
13 ensure this "adequate nursing service" will require  
14 maximum utilization of personnel and the program of  
15 service itself must be sufficiently flexible to adjust  
16 readily to the changing health needs of the community.

17 11. From this main objective of service have  
18 developed the four major concerns of the nursing pro-  
19 fession, viz. nursing service, nursing education,  
20 recruitment and research. Those who provide the  
21 nursing service today are endeavouring to maintain and  
22 improve existing service in the face of an unprecedent-  
23 ed increase in demand for service. All agencies re-  
24 quiring nursing personnel look to schools of nursing  
25 for the reinforcements which they will require. Thus  
26 nursing education is faced with a major task of pre-  
27 paring not only increased numbers but adequately and  
28 appropriately prepared personnel.

29 12. Recruitment must be given much greater  
30 attention not only by the profession but by those who

The Provincial Department of Health, Civil Defence

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gram, namely, recruitment and research, education, training

and continuing education. Those who provide the

nursing service today are endeavouring to maintain and

improve existing service in the face of an unprecedented

increase in demand for service. All agencies re-

sponding nursing personnel look to schools of nursing

for the reinforcements which they will require. Thus

nursing education is faced with a major task of pro-

ducing not only increased numbers but adequately and

appropriately prepared personnel.

### 12. Recruitment must be given much greater

attention not only by the profession but by those who



1 require nursing service if they are to obtain the  
2 needed personnel to enable them in due course to  
3 fulfil their responsibility to provide health care in  
4 the community. To make the best possible use of the  
5 nursing resources and to provide an economical yet  
6 educationally sound program for the student of nursing,  
7 considerable research must be undertaken in the fields  
8 of nursing service and of nursing education in order  
9 that we may more clearly define the pathways we should  
10 follow.

### 11 III. NURSING SERVICE

12  
13 13. Quantity. In the last decade many  
14 surveys (Report on the Survey of Nursing Facilities  
15 and Nursing Education Needs in Nova Scotia under the  
16 Federal Health Survey Grant, 1950, E. MacLennan) (Survey  
17 of Nursing Services and Requirments in Nova Scotia  
18 Hospitals, 1956 with Revisions 1959, F. Gass) have been  
19 undertaken in the United States and a few in Canada in  
20 an endeavour to establish adequate standards or ratios  
21 of nurses to patients in active, chronic, and specialized  
22 services. In applying the recommended standards to our  
23 situation in Nova Scotia, a study (Survey of Nursing  
24 Services and Requirements in Nova Scotia Hospitals, 1956  
25 with Revisions 1959, F. Gass) in which the figures  
26 were projected to 1965, reveals the need for an addi-  
27 tional 1200 nurses. In considering the provision of nur-  
28 sing service we need to take into account non-profession-  
29 al personnel such as the nursing assistants or aides and  
30 orderlies. Referring to the same survey, the numbers





regarding nursing service if they are to obtain the  
needed personnel to enable them in due course to  
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the community. To make the best possible use of the  
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an endeavour to establish adequate standards or ratios  
of nurses to patients in acute, chronic, and specialized  
services. In applying the recommended standards to our  
situation in Nova Scotia, a study (Survey of Nursing  
Services and Requirements in Nova Scotia Hospitals, 1956  
with Revisions 1959, F. Gass) in which the figures  
were projected to 1965, reveals the need for an addi-  
tional 1800 nurses. In considering the provision of  
nursing care as we need to take into account non-profession-  
al personnel such as the nursing assistants or aides and  
orderlies. Referring to the same survey, the numbers



1 needed in this category stand at 400 out of the 1200  
2 total requirement. These figures indicate the  
3 immediate need to provide increased training facilities  
4 for the nursing assistant and an intensified  
5 program for recruitment for both categories of  
6 personnel.

7 14. The source of professional personnel  
8 is the school of nursing. The same survey (F. Gass)  
9 reveals that only 21 per cent of each new class of  
10 graduates can be counted upon as net gain in per-  
11 sonnel. This is an appalling picture and again  
12 indicates the necessity for launching an intensive  
13 recruitment program. This topic will be considered  
14 later under Recruitment. There is one approach  
15 to the shortage in Nova Scotia that we must face in  
16 any attempts to increase the net gain from our gradua-  
17 ting classes, namely, to improve personnel policies,  
18 conditions of work, salaries, and other measures which  
19 will contribute to the economic security and welfare  
20 of our nurses. A stabilized, contented staff will  
21 be reflected in improved nursing service to the patient.

22 15. The employment of the nursing assistant  
23 in the nursing situation implies that the professional  
24 personnel must assume more responsibility, guidance and  
25 leadership. The proper utilization of all personnel  
26 is an area which needs to be carefully studied. The  
27 fact that nursing assistants have been brought into  
28 the hospital setting has not resulted in any marked  
29 improvement in the nursing service situation. The  
30 registered nurse is still the person more available



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1 around the clock for many odd jobs that need doing.  
2 The elimination of many of the non-professional tasks  
3 has been urged by nursing administrators for some  
4 time past. Again, our studies show that too great a  
5 percentage of nurses' time is spent in doing labora-  
6 tory, housekeeping, medical and portering and other  
7 small services. This situation indicates the need  
8 for studies being done in other departments of hospitals  
9 as well as in the nursing department.

10 16. (b) Quality. The improvement in the  
11 quality of nursing care is a much more difficult thing  
12 to achieve than an increase in the quantity of nursing  
13 care. Many in the profession are giving serious  
14 thought to the goodness of nursing care - what con-  
15 stitutes good nursing care? Criteria for improvement  
16 seem to defy identification in many ways. Quality  
17 seems to be a relevant thing. Standards for goodness  
18 vary from region to region and also in the expression  
19 of opinion from one person to the next. One common  
20 factor which seems to stand out a little more clearly  
21 than the others is the factor of time as related  
22 to nursing care. Attempts have been made to measure  
23 quality in terms of time, and ratios have been  
24 evolved which administrators endeavour to achieve.  
25 (F. Cass op. cit).

#### 26 IV. NURSING EDUCATION

27 17. The Canadian Nurses' Association has  
28 just launched a School Improvement Program to assist  
29 the schools across Canada to improve their educational  
30



around the clock for many of the jobs that need doing.  
The elimination of many of the non-professional tasks  
has been urged by nursing administrators for some  
time past. Again, one might know that for most a  
percentage of nurses' time is spent in doing other  
work, housekeeping, medical and portering and other  
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than the others is the factor of time as related  
to nursing care. Attempts have been made to measure  
quality in terms of time, and ratios have been  
evolved which administrators endeavor to achieve.  
(b) Cost, etc.

#### IV. NURSING EDUCATION

17. The Canadian Nurses' Association has  
been instrumental in a national improvement program to see



1 programs and to up-grade their schools of nursing.

2 If Nova Scotia schools are to benefit from this ser-  
3 vice our schools are faced with the prospect of em-  
4 ploying more instructors and supervisory personnel.

5 The clinical areas in which the students receive their  
6 experience should be under the administration of  
7 qualified head nurses. This, I may safely say, is  
8 one of the weakest spots in our nursing education  
9 scheme. The head nurse is literally the keystone in  
10 the arch of nursing service and yet we find her to be  
11 the individual most frequently unprepared for this very  
12 important position.

13 18. The necessity for professional nurses  
14 to assume positions of leadership lead one to the  
15 conclusion that a greater portion of nursing students  
16 must be directed to university schools of nursing  
17 where specific instruction in leadership, supervision  
18 and administration principles are taught. This in  
19 turn leads to the problem of the financing of nursing  
20 education - whether diploma schools or university  
21 schools, whether in university or out of university.  
22 Full credit is given to the Nova Scotia Government  
23 for their generosity in providing assistance to nursing  
24 education under their Hospital Insurance Plan. This  
25 has taken a great load of worry from the directors of  
26 nursing and nursing education but it is not a complete  
27 answer to the problem of nursing education. There is  
28 still room to debate the justification for a service  
29 institution to be conducting and controlling an educa-  
30 tional programme. One or other of the activities will





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still room to debate the justification for a separate  
institution to be conducting and controlling an educa-  
tional programme. One or other of the following will



1 eventually suffer due to the conflict of purposes and  
2 objectives.

3 19. The statement is frequently heard  
4 that in our present system of hospital schools the  
5 student is "exploited" to meet the nursing service  
6 needs of the hospital. Someone recently reversed  
7 the statement and queried whether the student was not  
8 now being "exploited" by nursing education. There  
9 may be a grain of truth in each statement! Recent  
10 studies (Unpublished material - "Evaluation of  
11 Schools of Nursing in Nova Scotia," 1960) of our schools  
12 in Nova Scotia show a marked improvement in this regard  
13 and that the "exploitation" evil is being eliminated  
14 to a very large extent.

15 20. However, the nursing personnel situa-  
16 tion in Nova Scotia is fast reaching the critical  
17 point. Ways and means must be found for increasing  
18 the facilities for teaching in the existing schools or  
19 by establishing additional schools. Serious con-  
20 sideration should be given to experimentation with  
21 new patterns of nursing education which will utilize  
22 more fully the resources of clinical experience avail-  
23 able in this province. This may necessitate major  
24 adjustments in the present nursing program but we are  
25 faced with the situation where change will come about,  
26 initiated by ourselves and according to our likes, or,  
27 initiated by a group or groups outside the profession  
28 and beyond our control.

29 21. A program of institutes, refresher  
30 courses and inservice programs should be established



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### CONCLUSION

19. The argument is frequently heard

that in our present system of hospital schools the

student is "exploited" to meet the nursing service

needs of the hospital. Someone recently remarked

the statement and queried whether the student was not

now being "exploited" by nursing education. There

may be a grain of truth in each statement. Recent

studies (unpublished material - "Evaluation of

Schools of Nursing in New South Wales, 1961") of 100 schools

in New South Wales show a marked improvement in this regard

and that the "exploitation" still is being eliminated

to a very large extent.

20. However, the nursing personnel themselves

in New South Wales are fast reaching the critical

point. Ways and means must be found for increasing

the facilities for teaching in the existing schools or

by establishing additional schools. Serious con-

sideration should be given to experimentation with

the following proposals:

21. Fully the resources of clinical experience available

in the hospitals. This may necessitate major

adjustments in the present nursing program but we are

faced with the situation where change will come about

whether we ourselves are ready or not. It is, in fact,

dictated by a group of forces outside the profession

and beyond our control.

22. A program of institutes, workshops

courses and service programs should be established





1 in Nova Scotia. The many details of the adminis-  
2 tration, financing, recruitment, etc. for any such  
3 new programs have not been thought thgouth.

4 22. We have been too cautious and too un-  
5 imaginative in designing solutions for many of our  
6 problems. It is within our legal power as an  
7 association to revamp and revitalize nursing educa-  
8 tion and bring it into line with present-day needs,  
9 but it is beyond our Association's financial re-  
10 sources to embark on any extensive revolutionary  
11 programme.

#### 12 V. RECRUITMENT

13 23. In considering the needs of nursing  
14 service and nursing education it is obvious that the  
15 lack of personnel is still acute in our province.  
16 A vigorous recruitment program must be undertaken at  
17 once. In the light of the many advances resulting  
18 in more complex nursing procedures in the medical  
19 and surgical fields, the candidate for nursing must  
20 be more carefully selected. With the introduction of  
21 auxiliary nursing personnel the onus for direction  
22 and supervision is on the registered nurse. This  
23 implies a standard of intelligence and nursing edu-  
24 cation beyond that of the non-matriculated high  
25 school student. I am loathe to admit that the  
26 minimum requirement for admission to schools of  
27 nursing in Nova Scotia stands now at less than Junior  
28 matriculation. Granted we require three years of high  
29 school, but our Act reads, "Grade XI Pass Certificate  
30

to Nova Scotia. The many details of the situation, financial, personnel, etc. for any such new program have not been thought through. We have been too cautious and too unimaginative in designing solutions for many of our problems. It is within our legal power as an association to revamp and revitalize nursing education and bring it into line with present-day needs. But it is beyond our association's financial resources to embark on any extensive revolutionary program.

# V. RECOMMENDATIONS

28. In considering the needs of nursing service and nursing education in its various fields, the lack of personnel is still acute in our province. A vigorous recruitment program must be undertaken at once. In the light of the many advances resulting in more complex nursing procedures in the medical and surgical fields, the candidate for nursing must be more carefully selected. With the introduction of auxiliary nursing personnel the ones for direction and supervision lie on the registered nurse. This implies a standard of intelligence and nursing education beyond that of the non-matriculated high school student. I am aware to admit that the minimum requirement for admission to schools of nursing in Nova Scotia stands now at less than Junior matriculation. Granted we require three years of high school, but our Act reads, "Grade XI has completed."



1 of Nova Scotia". However, many schools of nursing  
2 have their own standards and require complete  
3 matriculation and do practise careful selection in  
4 favour of the best prepared candidate. This I  
5 realize is a situation that can only be remedied  
6 locally but I take this opportunity of bringing it  
7 to the attention of the citizens of Nova Scotia that  
8 we have legally the lowest standard in Canada for  
9 admission to a school of nursing. In plans for the  
10 next revision of the Registered Nurses' Act is a  
11 request that the minimum entrance requirement to  
12 schools of nursing be raised to complete matricula-  
13 tion.

14 24. Another factor in recruitment is the  
15 number of available candidates for nursing. According  
16 to a Dominion Bureau of Statistics Survey the national  
17 average expectancy rate is one out of every ten girls  
18 graduating from school with complete Junior matri-  
19 culation. Applying this ratio to our Nova Scotia  
20 statistics the total number of candidates falls below  
21 the required number needed to supply our estimated  
22 need. (F. Cass op. cit). We are well aware of  
23 the competition which nursing faces in attracting the  
24 high school girl to the profession. Nursing is no  
25 longer the most glamorous of the professions. There  
26 are many other types of hospital personnel that make  
27 their appeal - whose programs of education are shorter  
28 in time, financial assistance is more readily available  
29 and whose graduate salaries have proved to be consider-  
30 ably higher immediately on graduation.







V. NURSING RESEARCH

25. Reference has been made to the many problems existing in nursing. Some of them are undoubtedly of our own making, but many of them have evolved from a changing society, an increased population, and changes in medical practice. Before the inevitable changes are made in nursing practice and methods of education, careful investigation should be undertaken to ensure that the most efficient yet economic service will be provided. These investigations may require the application of major scientific research methods or they may be effectively carried on as simple studies, but by whatever method, they must be done before we can hope to plan effectively for the future.

26. Studies are necessary - (a) to determine effective utilization of nursing personnel in hospitals and public health agencies, based on a determination of nursing needs. This would conceivably involve job analyses, work simplification methods, studies of functions with the agency or hospital - to mention just a few aspects; (b) in connection with the establishment of schools for nursing assistants, whether they should be established in connection with vocational schools, in regional centres with hospitals, or in combination with existing schools of nursing; (c) to determine the most expedient and effective means of preparing nurses to ensure both quality and quantity in the nursing services. Inherent in this is a determination of what knowledge and skills the nurse must have to meet the

# V. Nursing Research

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most efficient and effective means of preparing nurses

to meet both quality and quantity in the nursing ser-

vices. Research in this is a determination of what





1 health needs of society; (d) other areas awaiting  
2 serious study are costs of nursing education, factors  
3 in selection of students, curricula for various types  
4 of preparation and many other items.

## 5 VI. CONCLUSIONS

6 The following conclusions are based on data  
7 presented in the main Brief, regarding Nursing Service  
8 (Pars. 13 - 16 inc.)

9 27. The fundamental need in the nursing  
10 situation in Nova Scotia would seem indisputably to be  
11 more nurses. According to the most recent survey  
12 findings it is estimated that 1200 additional nurses  
13 will be required to staff the hospital alone, not  
14 including the needs of all other fields of nursing  
15 service. As indicated in the Brief these figures are  
16 projected only to 1965 - a period now within sight.

17 A revision of figures projected over the next 25 years  
18 would require more time to prepare than has been  
19 granted for the preparation of this Brief.

20 28. The personnel requirements in all other  
21 fields of nursing are increasing at an alarming rate,  
22 though no figures of sufficient recency to be valid  
23 are available for inclusion in this presentation.  
24 Regardless of the field of nursing in which a nurse  
25 chooses to work she is a product of the school of  
26 nursing. Thus the source of supply for all types of  
27 nurses is the school of nursing. Therefore those who  
28 employ nurses must bear some responsibility for  
29 assisting with the problem of supply.  
30





29. Less tangible than quantity but more important to good nursing service is the factor - quality. The essence of good nursing care is to be found in the conscience and personality of the individual nurse, but we hopefully endeavour to measure goodness by relating the activity to a period of time. The interplay between the performance of the individual and the effort of the total staff in a given situation determines in the long run the "quality or standard" of nursing service. The technical and ethical preparation of the nurse is the task of the school of nursing and in the final analysis the school of nursing is responsible for the quality of nursing service rendered in the hospital or agency.

30. regarding Nursing Education (Pars. 17-22)  
Schools of nursing should be organized upon a sound educational basis. As far as possible they should be operated by universities in conjunction with large hospitals which would develop affiliations with other general and special hospitals and with public health agencies.

31. The curriculum for nursing education should be revised and redesigned to prepare the nurse for the many new tasks required of nurses in today's world.

32. Schools of nursing should be operated on a budget reflecting the cost of operation and the value of service rendered by students to the associated hospitals and community agencies.

33. regarding Nursing Research (Paragraphs







25 - 26 incl.)

There is a great need for research in nursing problems. Fundamental, scientific research as well as minor studies should be promoted in hospitals associated with medical schools and in such others as have competent scientists and facilities available.

34. regarding Recruitment (Pars. 23 - 24).

Recruitment should be started in the Junior High School with an intensive placement programme to be followed up in the Senior High School period.

35. All recruitment should be for The Profession, not for specific schools of nursing.

36. Provincial organizations interested in nursing education should be encouraged to contribute funds to nursing recruitment programmes.

37. Responsibility for recruitment rests with all organizations - lay and professional, which have an interest in health.

38. In this short Brief no attempt has been made to present a comprehensive picture of nursing affairs in Nova Scotia. We have endeavoured rather to draw attention to those aspects of nursing activities which are subject to control by this Association, and to give some indication whether we, as an Association, are ready and able to provide the nursing services required in a Health Program.



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1 MISS MYERS: As President of the Registered  
2 Nurses of Nova Scotia, I am pleased to introduce Miss  
3 Electa MacLennan, who has been chosen by our Association  
4 to present the submission, and also answer any questions.

5 MISS MacLENNAN: Although I was chosen to  
6 present the brief, it was prepared by a Committee of the  
7 Registered Nurses' Association of Nova Scotia. I would  
8 like to present conclusions, but to speak very briefly to  
9 some of the paragraphs in the brief. We have set forth  
10 for your information some of the powers of the Association  
11 in the first pages of the brief.

12 Paragraph 12 - Recruitment must be given  
13 much greater attention not only by the profession but by  
14 those who require nursing service if they are to obtain  
15 the needed personnel to enable them in due course to fulfill  
16 their responsibility to provide health care in the  
17 community. To make the best possible use of the nursing  
18 resources and to provide an economical yet educationally  
19 sound program for the student of nursing, considerable  
20 research must be undertaken in the fields of nursing ser-  
21 vice and of nursing education in order that we may more  
22 clearly define the pathways we should follow.

23 So I have developed a few pages of the brief  
24 under those four headings, nursing service, nursing educa-  
25 tion, recruitment and research.

26 So that in the conclusions, paragraph 27,  
27 regarding nursing service (paras. 13-16 incl.) The funda-  
28 mental need in the nursing situation in Nova Scotia would  
29 seem indisputably to be more nurses. According to the  
30 most recent survey findings, '59 by date, I believe, it is

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the needed personnel to enable them in our country to fulfill

their responsibility to provide health care in the

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and program for the study of nursing, consistently

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vice and of nursing education in order that we may more

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mental need in the nursing situation in Nova Scotia would

seem indisputably to be more nurses. According to the

most recent survey findings, '59 in fact, I believe, it is





1 estimated that 1200 additional nurses will be required to  
2 staff the hospitals alone, not including the needs of all  
3 other fields of nursing service. As indicated in the  
4 brief, these figures are projected only to 1965 - this need  
5 for 1200 in hospitals, and that figure is now almost within  
6 sight. A revision of figures projected over the next 25  
7 years would require more time to prepare than has been  
8 granted for the preparation of this brief.

9 This has been elaborated on briefly in  
10 paragraphs 13 to 16 of the brief.

11 The personnel requirements in all other  
12 fields of nursing are increasing at an alarming rate,  
13 though no figures of sufficient recency to be valid are  
14 available for inclusion in this presentation. Regardless  
15 of the field of nursing in which a nurse chooses to work  
16 she is a product of the school of nursing. Thus the  
17 source of supply for all types of nurses is the school of  
18 nursing. Therefore those who employ nurses must bear some  
19 responsibility for assisting with the problem of supply.

20 Less tangible than quantity but more impor-  
21 tant to good nursing service is the factor of quality.  
22 The essence of good nursing care is to be found in the  
23 conscience and personality of the individual nurse, but we  
24 hopefully endeavour to measure goodness by relating the  
25 activity to a period of time. The interplay between the  
26 performance of the individual and the effort of the total  
27 staff in an institution in a given situation determines  
28 in the long run the "quality or standard" of nursing  
29 service. The technical and ethical preparation of the  
30 nurse is the task of the school of nursing thus in the





1 estimated that 1500 additional nurses will be required to  
 2 staff the hospitals alone, not including the needs of all  
 3 other fields of nursing service. As indicated in the  
 4 brief, these figures are projected only to 1965 - this does  
 5 not take into account the fact that the health service  
 6 is likely to expand in the future. It is therefore  
 7 probable that the figures for 1965 are too low.  
 8 The figures for 1965 are therefore too low.

9 The personnel requirements in all other  
 10 fields of nursing are increasing at a similar rate.  
 11 Although no figures of sufficient accuracy to be valid are  
 12 available for inclusion in this presentation, regardless  
 13 of the fact that the figures for 1965 are too low.  
 14 The figures for 1965 are therefore too low.  
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21 service. The technical and ethical organization of the



1 final analysis the school of nursing is responsible for  
2 the quality of nursing service rendered in the hospital  
3 or agency.

4                   Regarding Nursing Education (paras. 17-22)

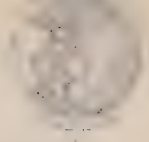
5                   Schools of nursing should be organized  
6 upon a sound educational basis. As far as possible they  
7 should be operated by universities in conjunction with  
8 large hospitals which would develop affiliations with  
9 other general and special hospitals and with public health  
10 agencies.

11                   I would like to qualify that statement. In  
12 the body of the brief, I have been referring specifically  
13 to the qualities of leadership which nurses must assume,  
14 and this preparation is to be found in the University  
15 school, and I must say I have made an invalid assumption,  
16 maybe a mistake, in saying that they should be qualified  
17 in the word University, and I want to qualify the word  
18 University. Although I have used the word should, it  
19 should not be too long, but at the present time we are  
20 not prepared to make the statement that all nursing educa-  
21 tion should be in the Universities. I want to qualify  
22 that for our membership, as well as for the Commission.

23                   The curriculum for nursing education should  
24 be revised and redesigned to prepare the nurse for the  
25 many new tasks required of nurses in today's world.

26                   Schools of nursing should be operated on a  
27 budget reflecting the cost of operation and the value of  
28 service rendered by students to the associated hospitals  
29 and community agencies.

30                   Regarding Nursing Research (paras. 25-26 incl.)



1 final analysis the school of nursing is responsible for  
2 the quality of nursing services rendered in the hospital  
3 or agency.

4 Regarding Nursing Education (pages. 17-22)

5 Schools of nursing should be organized  
6 upon a sound educational basis. As far as possible they  
7 should be operated by universities in connection with  
8 large hospitals which would develop affiliations with  
9 other general and special hospitals and with public health

10 I would like to qualify this statement. In  
11 the body of the report, I have been referring specifically  
12 to the qualities of leadership which nurses must assume,  
13 and this reputation is to be found in the University  
14 school, and I must say I have made an invalid assumption,  
15 maybe a mistake, in saying that they should be qualified  
16 in the word University, and I want to qualify the word  
17 University. Although I have used the word should, it  
18 should not be too long, but at the present time we are  
19 not prepared to make the statement that all nursing educa-  
20 tion should be in the Universities. I want to qualify  
21 that for our membership, as well as for the Committee.

22 We realized and endeavored to prepare the nurse for the  
23 many new tasks required of nurses in today's world.

24 Schools of nursing should be operated on a  
25 budget reflecting the cost of operation and the value of  
26 services rendered by students to the associated hospitals  
27 and community agencies.

28 Regarding Nursing Research (pages. 23-25 incl.)





1                   There is a great need for research in  
2 nursing problems. Fundamental, scientific research as  
3 well as minor studies should be promoted in hospitals  
4 associated with medical schools and in such others as have  
5 competent scientists and facilities available.

6                   I would like just briefly to indicate some  
7 of these topics which we feel are crying out to be studied  
8 before we can really say in what direction nursing should  
9 be going.

10                  Studies are necessary - (a) to determine  
11 effective utilization of nursing personnel in hospitals  
12 and public health agencies, based on a determination of  
13 nursing needs. This would conceivably involve job analy-  
14 ses, work simplification methods, studies of functions  
15 with the agency or hospital - to mention just a few aspects;  
16 (b) in connection with the establishment of schools for  
17 nursing assistants, whether they should be established in  
18 connection with vocational schools, in regional centres  
19 with hospitals, or in combination with existing schools of  
20 nursing; (c) to determine the most expedient and effective  
21 means of preparing nurses to ensure both quality and quan-  
22 tity in the nursing services. Inherent in this is a deter-  
23 mination of what knowledge and skills the nurse must have  
24 to meet the health needs of society; (d) other areas  
25 awaiting serious study are costs of nursing education,  
26 factors in selection of students, curricula for various  
27 types of preparation and many other items.

28                  Paragraph 34 refers to Recruitment - Recruit-  
29 ment should be started in the Junior High School with an  
30 intensive placement program to be followed up in the

There is a great need for research in

existing problems. Fundamental, scientific research is

well as minor studies should be promoted in hospitals

associated with medical schools and in such others as have

I would like first briefly to indicate some

of these topics which we feel are crying out to be studied

before we can really say in what direction nursing should

be going.

Studies are necessary - (a) to determine

effective utilization of nursing personnel in hospitals

and public health agencies, based on a determination of

nursing needs. This would encompass the five job analysis

and work simplification methods, studies of functions

with the agency or hospital - to mention just a few aspects

(b) in connection with the establishment of standards for

nursing standards whether they should be established in

connection with vocational schools, in regional centres

with hospitals, or in connection with existing schools of

nursing; (c) to determine the most efficient and effective

means of preparing nurses to ensure both quality and quantity

in the nursing services. Inherent in this is a later

attention of what knowledge and skills the nurse must have

to meet the health needs of society; (d) other areas

existing serious study are areas of nursing education,

factors in selection of students, curricula for various

types of preparation and many other items.

Paragraph 2 refers to Research - Research

has been started in the Junior High School with an

intensive planning program to be followed up in the





1 Senior High School period.

2 All recruitment should be for The Profession,  
3 and I have deliberately capitalized The Profession, not  
4 for specific schools of nursing.

5 They can go out on their own campaigns, but  
6 we feel that the community should be involved in nursing  
7 recruitment.

8 Provincial organizations interested in  
9 nursing education should be encouraged to contribute funds  
10 to nursing recruitment programs.

11 Responsibility for recruitment rests with  
12 all organizations - lay and professional, which have an  
13 interest in health.

14 In this short Brief no attempt has been made  
15 to present a comprehensive picture of nursing affairs in  
16 Nova Scotia. We have endeavoured rather to draw attention  
17 to those aspects of nursing activities which are subject to  
18 control by this Association, and to give some indication  
19 whether we, as an Association, are ready and able to provide  
20 the nursing services required in a Health Program.

21 In the introduction I have asked for the  
22 privilege of presenting our supplementary budget, and in  
23 the supplementary budget our Committee felt that we would be  
24 prepared to see if we could find some reliable figures on  
25 cost of nursing education relative to Nova Scotia's own  
26 costs.

27 There are studies which have been done on  
28 experiments up to 1952, and I am not an economist to  
29 realize what the value of the 1952 dollar is today, and  
30 since there have been studies of costs of experimental



1/1 recruitment should be for the profession.

and I have deliberately capitalized The Profession, not

for specific schools of nursing.

They can go out on their own campaign, but

we feel that the community should be involved in nursing.

Professional organizations interested in

nursing education should be encouraged to contribute funds

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Responsibility for recruitment rests with

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whether we, as an Association, are ready and able to provide

the nursing services required in a Health Program.

In the introduction I have asked for the

privilege of presenting our supplementary budget, and in

the supplementary budget our Committee felt that we would be

prepared to see if we could find some reliable figures on

cost of nursing education relative to Nova Scotia's own

costs.

There are studies which have been done on

expenditures up to 1955, and I am not an economist in

since there have been studies of costs of education.



1 programs, but not of, shall I say, the average across the  
2 board nursing educational program as we now have it.

3 Two years ago, with the introduction of the  
4 Nova Scotia Hospital Commission, the schools of nursing  
5 in Nova Scotia were encouraged and required to present a  
6 budget. I feel that after several years of experience of  
7 budgeting under the Nova Scotia Hospital Commission, we  
8 might reasonably ask for a study of costs as represented  
9 in their budget, and thereby come up with a figure. We  
10 may be able, after two years' experience, with the co-opera-  
11 tion and permission of the Government of Nova Scotia and  
12 the Hospital Commission, to come up with something for you  
13 before next May. We will certainly approach the Commission  
14 with that in view.

15 I think those are the only points at this  
16 point that we wanted to make. The Association is respon-  
17 sible for the control of its practitioners, the education  
18 and preparation of its practitioners, and the examination  
19 of its practitioners. We have not included any statement  
20 about our service programs, because we, as an Association,  
21 do not conduct service programs, but I perhaps should say  
22 here verbally we are prepared, as an Association, to go  
23 along with and to support whatever health program requiring  
24 nursing services that will give the best service to the  
25 people of Canada.

26 THE CHAIRMAN: Thank you very much, Miss  
27 MacLennan.

28 COMMISSIONER BALTZAN: Just one simple  
29 question, compared with the situation relating to medical  
30 students, and we are dealing with nursing students, could



1 but not of, shall I say, the average nurse on  
2 board nursing educational program as we now have it.  
3 Two years ago, with the introduction of the  
4 Nova Scotia Hospital Commission, the schools of nursing  
5 at this point were...  
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1 you say, or tell us some time later, which of the two is  
2 the greatest difficulty, or if the difficulty is in both  
3 ways, and if there is sufficient attraction to the profes-  
4 sion, if you have a shortage of nurses, or whether it is  
5 a lack of training facilities for applicants that is a big  
6 barrier to enrolment?

7 MISS MacLENNAN: Our complete answer will  
8 have to wait further study, but we are feeling now in the  
9 reflection of the program conducted in our hospitals under  
10 the auspices of our Department of Education that at the  
11 moment nursing is not enjoying the top position in glamour  
12 professions, partly because of the length of time to become  
13 a registered nurse, and then the low salary and other  
14 items in working conditions do not compare favourably with  
15 some of the professions where the period of preparation  
16 is shorter and the initial salary higher. Then, as far as  
17 the sheer numbers, with respect to the provision of nursing  
18 personnel, we don't have sufficient facilities for prepa-  
19 ring enough nurses at the moment.

20 COMMISSIONER GIRARD: Miss MacLennan, on  
21 page 4, under nursing service, paragraph 13, you mentioned  
22 a few minutes ago that there were a number of studies or  
23 research projects in nursing that were just crying out to  
24 be done. I wonder if you would consider that one that  
25 should have priority would be one in which you could  
26 establish adequate standards or ratios of nurses to  
27 patients in active, chronic and specialized services. You  
28 do say here: "In applying the recommended standards in  
29 Nova Scotia". This week, on Monday, in the brief presented  
30 by the Government of Nova Scotia, in the nursing section,

1 You say, or tell us some time later, which of the two is  
2 the greatest difficulty, or is the difficulty in both  
3 ways, and if there is sufficient attraction to the profes-  
4 sion, if you have a shortage of nurses, or whether it is  
5 a shortage of nurses, or whether it is  
6 a barrier to recruitment?

7 MISS MATHIAS: Our committee agrees with  
8 have to wait further study, but we are feeling now in the  
9 reflection of the program conducted in our hospitals under  
10 the auspices of our Department of Education that at the  
11 moment nursing is not enjoying the top position in Glasgow  
12 professional, partly because of the length of time to become  
13 a registered nurse, and then the low salary and other  
14 items in working conditions do not compare favorably with  
15 some of the professions where the period of preparation  
16 is shorter and the initial salary higher. Then, as far as  
17 the sheer numbers, with respect to the provision of nursing  
18 personnel, we don't have sufficient staffs for general  
19 nursing enough nurses at the moment.

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1 the ratio that was given was 3.5 hours of nursing per  
2 patient. Do you feel that this is still an adequate  
3 ratio? Do you feel that the question of ratio is impor-  
4 tant in view of the fact that nurses throughout Canada  
5 will have to come up with the quantities? How many nurses  
6 will we need for this, that and the other service, and  
7 how will we get, what method will we use to estimate these  
8 nurses? After this, it is also related I believe to cost,  
9 because the number of nurses of course is directly related  
10 to cost, so it would be very interesting for the Commission  
11 I think to get your point of view on this.

12 MISS MacLENNAN: One of the reasons that I  
13 deliberately omitted any 3.5's and 3.45's in this survey,  
14 was because the most recent figure we have in Nova Scotia  
15 was the one I used on the footnote, the 3.5, but there  
16 have been experiments carried out at individual hospitals  
17 in Canada and the United States which are coming up with a  
18 different ratio, 4.6, and up to 5 point something. We  
19 didn't have time in our preparation to write away and get  
20 the actual data on these, and as I say, our own figures  
21 were 57 to 59, which we felt were a little outdated for  
22 the 1961 Commission, but we feel, as an Association, and  
23 as nurses in the profession, that a reasonable ratio of  
24 time is perhaps one of the -- it is going to be the basic  
25 measure, and we need to determine a more valid ratio of  
26 nurse to the time she spends with a patient. You see, the  
27 nurse to bed isn't as valid a measure as the amount of  
28 time which the nurse spends with the patient. You can have  
29 a nurse that has 100% in her examination, and she can have  
30 a personality that sends that patient right out of Dr.





1 patient. Do you feel that this is still an adequate  
3 ratio? Do you feel that the question of ratio is impor-  
4 tant in view of the fact that nurses throughout Canada  
5 will have to come to grips with the question? How many nurses  
6 will we need for this, not only the other services, and  
7 how will we get it? What method will we use to estimate the  
8 nurses? After this, as I have related I believe to cost,  
9 because the number of nurses of course is directly related  
10 to cost, so it would be very interesting for the Committee  
11 I think to get your point of view on this.  
12 MISS MURPHY: One of the reasons that I  
13 deliberately omitted say 2.5 and 2.4 in this survey,  
14 was because the most recent figure we have in Nova Scotia  
15 was the one I used on the footnote, the 3.5, but there  
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25 time is perhaps one of the -- it is going to be the brain  
26 measure, and we need to determine a more valid ratio of  
27 nurse to the time the agent with a patient. You see, the  
28 nurse to bed isn't as valid a measure as the amount of  
29 time which the nurse spends with the patient. You can have



1 Jones' services.

2 COMMISSIONER GIRARD: If she has had affilia-  
3 tions?

4 MISS MacLENNAN: Yes, affiliations. So that  
5 the amount of nursing time, and also the ethical prepara-  
6 tion of the nurse, the Canadian Nurses' Association, in  
7 one of the national studies, has started a study of  
8 quality, and we are using a new phrase, trying to determine  
9 what is the goodness in nursing, you are going to hear  
10 that phrase quite often in the next two or three years,  
11 and we feel that goodness in nursing is related quite  
12 closely to the amount of time which the nurse is given to  
13 properly nurse her patient, and we certainly need major,  
14 scientific, accurate research to determine just how much  
15 time she requires to give the patient that good care.

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1 COMMISSIONER GIRARD: On page 5, paragraph  
2 14, you state: "The source of professional personnel is  
3 the school of nursing. The same survey reveals that only  
4 21% of each new class of graduates can be counted upon as  
5 net gain in personnel". Could you give us some explanation  
6 as to this figure?

7 MISS MacLENNAN: Again, we deliberately  
8 omitted statistics, but in the report which was prepared  
9 for the Hospital Insurance Commission, a formula was  
10 worked out in relation to the numbers of nurses that were  
11 entering the field in Nova Scotia, and they worked out  
12 with a 20% wastage already deducted, that with an enrolment  
13 of 300 nurses and with a 21% net gain from each graduating  
14 class, that over a period of three years they would only  
15 accrue an increase of 189 individual nurses to the end of  
16 1960. Then, anticipating the hospital construction program,  
17 where the clinical facilities would be increased, it was  
18 quite proper to assume the student body may be increased  
19 in those hospitals, and that we might look forward to an  
20 increased enrolment up to 400, and that is 100 more. So,  
21 in applying the same formula, the 20% wastage figure  
22 deducted, and allowing for a 30% addition accruing to the  
23 labour force, from our 400 we would expect 333 nurses to  
24 be available, and on a five-year basis carrying it through  
25 to the projection of 1965 we could expect to find coming  
26 into the working ranks 500 nurses, which gave us a total  
27 of 689 nurses out of the required 700 which the 1959 figure  
28 set out. So that formula, after you take out all the  
29 wastage, for various purposes, the new students left over  
30 made up a 21% gain in the nursing course.





1 COMMISSIONER GIRARD: Thank you, Miss  
2 MacLennan.

3 COMMISSIONER STRACHAN: Mr. Chairman, I have  
4 a couple of questions for Miss MacLennan. It has been  
5 stated that there is a lack of facilities for training,  
6 but is there a lack of applicants for those facilities?

7 MISS MacLENNAN: I believe the statement  
8 made at the Committee Meeting when the matter came up was  
9 that with the Fall class of 1961 our 14 schools of nursing  
10 had a complete roster of new students. I think that is as  
11 specific as I can be.

12 COMMISSIONER STRACHAN: What about preceding  
13 years -- nurses in training?

14 MISS MacLENNAN: Yes, the nurses in training:  
15 I would not want it to go in the record, but it is my  
16 feeling that for a few years in the 1950's, immediately  
17 post-war, that the classes were not all filled.

18 COMMISSIONER STRACHAN: I am thinking of  
19 those girls who are in training at present -- those who  
20 have entered two years ago and a year ago.

21 MISS MacLENNAN: I am afraid I can't give  
22 you a figure on that because the one we had pinpointed  
23 was the report of the schools of nursing for the 1961  
24 class. Just as a member at large of the Association, I  
25 don't have the feeling there has been any lack of applicants  
26 in the last five years, but I would not want that to be  
27 statistically stated.

28 COMMISSIONER STRACHAN: The other question,  
29 Mr. Chairman, is with respect to the statement made the  
30 other day that of last year's classes there was a 40%







1 failure: is that 40% entirely wasted? Is anything being  
2 done to recover them? They spend three years of their  
3 lives and have had three years of apparently good training:  
4 is there anything being done to recover that wastage and  
5 make some use of the time and instruction that has been  
6 given to them?

7 MISS MacLENNAN: Yes. Actually, I will  
8 repeat the answer which I gave to Miss Girard on Monday  
9 afternoon. The policy of the Association is to permit a  
10 student who fails an examination to re-write an indefinite  
11 number of times. We have no limitation on the times  
12 which an examination may be written. The usual time a  
13 student will be successful is on her second writing. We  
14 also have provision in our Act for the granting of a tempo-  
15 rary permit, so that as soon as a student finishes her  
16 1095 days of preparation, which is legally required by the  
17 Act, she may be granted, by the Association, a temporary  
18 permit to practise as a qualified registered nurse. That  
19 accounts for the time between the date of finishing and  
20 the date of the next sitting of the examination coming up.  
21 That same clause in the Act permits us to grant a temporary  
22 permit to a student who fails her examination, and she can  
23 function in her hospital. She cannot go to another  
24 Province. She is not yet an R.N., but she may work in her  
25 own hospital -- preferably in her own hospital -- but she  
26 can work in the Province. There is this legal provision,  
27 so that we make immediate use of the student. She can  
28 work the next day. She can put on her cap and pin and  
29 work.

30 COMMISSIONER STRACHAN: And if she has



1 returned to that 404 entirely wanted? Is anything being  
 2 done to recover them? They spent three years in their  
 3 lives and a few half three years of apparently good earnings  
 4 is there anything being done to recover that money and  
 5 make some use of the time and money that has been  
 6 given to them?

7 MISS MACLENNAN: Yes. Actually, I will  
 8 repeat the answer which I gave to Miss Gird on Monday  
 9 afternoon. The policy of the Association is to permit a  
 10 student who fails an examination to re-write an indefinite  
 11 number of times. We have no limitation on the times  
 12 which an examination may be written. The usual time a  
 13 student will be successful is on her second writing. We  
 14 also have provision in our Act for the granting of a tempo-  
 15 rary permit, so that as soon as a student finishes her  
 16 1005 days of preparation, which is legally required by the  
 17 Act, she may be granted, by the Association, a temporary  
 18 permit to practise as a qualified registered nurse. That  
 19 accounts for the time between the date of finishing and  
 20 the date of the next sitting of the examination coming up.  
 21 That same clause in the Act permits us to grant a temporary  
 22 permit to a student who fails her examination, and she can  
 23 function in her hospital. She cannot go to another  
 24 Province. She is not yet an R.N., but she may work in her  
 25 own hospital -- preferably in her own hospital -- but she  
 26 can work in the Province. There is this legal provision,  
 27 so that we make immediate use of the student. She can  
 28 work the next day. She can put on her cap and pin and  
 29 work.





1 enough stick-to-it-iveness, can that be progressed to the  
2 second and third time?

3 MISS MacLENNAN: Yes. We have been consi-  
4 dering putting a limit on the number of times which she  
5 might write without returning to the classroom for repeated  
6 instruction. We haven't come to any agreement how we can  
7 work out something like that because that is an administra-  
8 tion problem within the school of nursing, but at the  
9 present time there is an unlimited number of times she may  
10 re-write, with her own tutoring or whatever system she can  
11 devise for getting that knowledge.

12 THE CHAIRMAN: In connection with recruitment  
13 you have been talking of the high school girl going into  
14 the nursing school: what about the older person who, having  
15 graduated -- perhaps married and a family grown up -- have  
16 you any figures on the number of married women who return  
17 to nursing or are available for nursing at this later  
18 period?

19 MISS MacLENNAN: You mean the nurse who took  
20 her preparation as coming out of high school and married  
21 even a month before she graduated?

22 THE CHAIRMAN: Well, she was an R.N. for a  
23 day or several years.

24 MISS MacLENNAN: I don't have them at my  
25 fingertips, but we have data assembled by the Canadian  
26 Nurses' Association as well as some American figures.  
27 One of the figures in my mind is that on an average the  
28 life of the nurse is five years. Some of us work for 30  
29 years and some of us don't work at all, so the average  
30 comes out to about  $5\frac{1}{2}$  years. However, we can find for you



though some of it is, can that be projected to the

MISS MCKINNEY: Yes. We have been con-

sidering putting a limit on the number of times which the

right with, without returning to the situation for response

illustration. We haven't come to any agreement how we can

work out something like that because that is an educational

then problem within the school of nursing, but at the

present time there is an unlimited number of times the way

re-write, with her own learning or whatever system she can

device for getting that knowledge.

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the nursing school. What about the older person who, having

graduated -- perhaps married and a family grown up -- have

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her preparation as coming out of high school and married

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day or several years.

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fingerings, but we have data assembled by the Canadian

Nurses' Association as well as some American figures.

One of the figures in my mind is that on an average the

life of the nurse is five years. Some of us work for 30

years and some of us don't work at all, so the average

comes out to about 12 years. However, we can find for you





1 the exact number of nurses that return in the different  
2 areas and different Provinces.

3 THE CHAIRMAN: But is it a substantial  
4 figure in Nova Scotia?

5 MISS MacLENNAN: Yes, it is in Nova Scotia.  
6 We have a large number of married nurses working in all  
7 of our agencies -- public health and hospitals. The exact  
8 figure I can find for you eventually, but it is a substan-  
9 tial number.

10 I might add here we have facilities for the  
11 preparation of male nurses in Nova Scotia which all of the  
12 Provinces do not have, and we have a fair number of male  
2 13 nurses.

14 COMMISSIONER FIRESTONE: Mr. Chairman, I  
15 would like to congratulate Miss MacLennan and the Registered  
16 Nurses' Association of Nova Scotia for a particularly  
17 well written brief, and I would like to refer to one para-  
18 graph in particular, and that is paragraph 22 on page 8.  
19 This paragraph contains a statement of both humility and  
20 vision, and you say your Association has been too cautious  
21 and too unimaginative in designing solutions for many of  
22 your problems, and you say further it is within your  
23 legal power as an Association to revamp and revitalize  
24 nursing education and bring it into line with present-day  
25 needs, but that it is beyond your Association's financial  
26 resources to embark on any extensive revolutionary program.  
27 I believe, Miss MacLennan, you suggested you might make  
28 available to the Commission, a budget of what would be  
29 required to implement an expanded program, and if my  
30 memory is correct, you said "of extended nursing education".





the exact number of nurses that return in the different

This question, but as it is a substantial

figure in Nova Scotia?

MRS. MACKENZIE: Yes, it is in Nova Scotia.

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of our agencies -- public health and hospitals. The exact

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tial number.

I might add here we have facilities for the

preparation of nurse nurses in Nova Scotia which all of the

Provinces do not have, and we have a fair number of male

nurses.

COMMISSIONER FINESTON: Mr. Chairman, I

would like to congratulate Miss Mackenzie and the Registrar

Nurses' Association of Nova Scotia for a particularly

well written brief, and I would like to refer to one para-

graph in particular, and that is paragraph 22 on page 2.

This paragraph contains a statement of both families and

what, and you say your Association has been too cautious

and too unimaginative in designing solutions for many of

your problem, and you say further it is within your

legal power as an Association to revamp and reorganize

nursing education and bring it into line with present-day

needs, and that is in accord with your Association's function.

resources to embark on any extensive nursing study program.

I believe, Miss Mackenzie, you suggested you would make

available to the Commission, a budget of what would be

required to implement an expanded program, and if my

memory is correct, you said "or extended nursing education."



1 but in going over your brief I find you have many other  
2 recommendations as well in the field of research, and so  
3 on. So, if you present to the Commission a supplementary  
4 budget indicating what expenditures could be involved,  
5 could that cover all the recommendations which you have  
6 made in this brief, and could this cover the period of the  
7 next five years and could it deal with Nova Scotia, and  
8 could you then end up with suggestions of your Association  
9 on how such an extended program could be most appropriately  
10 financed?

11 MISS MacLENNAN: I think that is the direc-  
12 tion in which we were hoping to go, because the work of  
13 the Association is really quite clearly set forth. So,  
14 I think there should not be too much trouble in attempting  
15 something along that line.

16 COMMISSIONER FIRESTONE: Thank you very  
17 much. It is very helpful.

18 THE CHAIRMAN: Thank you very much.

19 Then, we have the brief from the Canadian  
20 Foundation for Poliomyelitis and Rehabilitation.

21 SUBMISSION OF THE CANADIAN FOUNDATION FOR  
22 POLIOMYELITIS AND REHABILITATION.

23 (Nova Scotia Chapter)

24 Appearances: Hon. Mr. Justice L.D. Currie, Q.C.,  
25 LL.D., President  
26 Mr. J.F. Fry, Executive Director

27 HON. JUSTICE CURRIE: My lord, and members  
28 of the Commission, my name is Currie and I am President  
29 of the Nova Scotia Chapter of the Foundation and Past-Presi-  
30 dent of the National Foundation. I think you will find  
our brief, if not the shortest, one of the shortest you



over your brief I find you have many other  
things as well in the field of research, and so  
So, if you present to the Commission a supplementary  
budget indicating what expenditures could be involved,  
could that cover all the recommendations which you have  
made in this brief, and would this cover the period of the  
next five years and could it deal with Nova Scotia, and  
could you then end up with suggestions of your Association  
on how much an extended program could be most appropriately  
financed?

MISS MASON: I think that is the direction in which we were hoping to go, because the work of  
the Association is really quite clearly set forth. So,  
I think there should not be too much trouble in attempting  
something along that line.

COMMISSIONER FORTSON: Thank you very  
much. It is very helpful.

THE CHAIRMAN: Thank you very much.

Then, we have the brief from the Canadian  
Commission for Historical Research and Interpretation.  
SUBMISSION OF THE CANADIAN COMMISSION FOR  
HISTORICAL RESEARCH AND INTERPRETATION

MR. JAMES GIBSON: My Lord, and members  
of the Commission, my name is James and I am President  
of the Nova Scotia Chapter of the Foundation and past-President  
of the National Foundation. I think you will find  
our brief, if not the shortest, one of the shortest you





1 have before you. There are several reasons for that: one  
2 is that the National Foundation will be presenting or has  
3 already presented a submission to you which will cover the  
4 national story, and to some extent the Provincial stories  
5 as well. Second, having been on occasion obliged to  
6 appear as counsel and in another capacity before various  
7 Commissions, and having been a member of a Commission  
8 myself, I have often wondered how there may be achieved  
9 some way of preventing the overlapping of information and  
10 statistical data by prior discussions beforehand. I  
11 suppose that is not practical, but there will be found  
12 running through all of these briefs matters which apply to  
13 us as well. For example, cost of rehabilitation, cost of  
14 orthopaedic surgery, facilities for treatment, and so on  
15 and so forth. They all apply to us and we haven't gone  
16 into any detail with respect to those because the problem  
17 was similar throughout.

18 Another reason is that we feel that polio  
19 is different from many other diseases. I think the trend  
20 of experience shows -- it may not be at all definitive --  
21 but the trend would appear to show that by the Salk  
22 vaccine and other vaccines which are in use it is possible  
23 to eradicate polio from this nation. Hence, all the  
24 figures that can be given with respect to rehabilitation,  
25 orthopaedic surgery, and so on, are relative, and that if  
26 we can take the steps to remove this disease from our  
27 midst then much of the public cost now involved, much of  
28 the voluntary contributions now being made, can be diverted  
29 for other services.

30 For example, I may say at times it has cost





1 us for one individual, up to \$12,000 to send that person  
2 to Ontario or New York for treatment alone before we begin  
3 the rehabilitation service looking to gainful employment.  
4 We collect in this Province more than any other health  
5 organization by voluntary contributions. It varies from  
6 \$70,000 to \$85,000. We could spend four times that much  
7 at the moment to take care of something of the order of  
8 1,000 active files which we have: that is, for rehabilita-  
9 tion, for education, for gainful employment, for a number  
10 of things.

11 For example, before the Health Commission  
12 work began we had over 300 polio patients who required  
13 operative surgery. With the incoming of the Health Commis-  
14 sion that cost of hospitalization has been lifted from our  
15 shoulders and we have been able to spend more money in the  
16 operative surgery field with the result we reduced last  
17 year the number to 100, and the maximum at the moment is  
18 40. However, we hope, sirs, that if there can be a program  
19 of intensive immunization wherein all the people of the  
20 nation can be inoculated with whatever vaccine the autho-  
21 rities prescribe as the best one, then all of these costs  
22 can be reduced to a minimum, and all we shall be required  
23 to do will be to care for those who are already on our  
24 active files.

25 In Nova Scotia -- and I do not say this, you  
26 will understand, in any boastful way -- but ours was the  
27 first Province to begin a Provincial-wide inoculation  
28 program. We did that through our chapter. We had no  
29 Government assistance. We paid for the doctors, we paid  
30 for the halls and the nurses -- we paid for everything,





no for one individual, up to \$12,000 to send that person  
to Ontario or New York for treatment alone before he began  
the rehabilitation process looking for gainful employment.  
We collected in this Province more than any other Province  
organization by voluntary contributions. It varies from  
\$70,000 to \$150,000. We would spend four times that each  
at the moment for some sort of something of the order of  
1,000 active cases which we have: that is, for rehabilitation  
tion, for education, for gainful employment, for a number  
for example, before the Health Commission  
work began as far over 200 before patients who required  
operative surgery. With the opening of the Health Commis-  
sion that sort of hospitalization has been lifted from our  
shoulders and we have been able to spend more money in the  
operative surgery field with the result we reduced last  
year the number to 100, and the maximum at the moment is  
100. However, we hope, since that if there can be a program  
which would be an ideal one, then all of these cases  
will be handled in any hospital way -- but ours was the  
first hospital to begin a Provincial-wide rehabilitation  
program. We did not through our chapter. We had no  
Government assistance. We paid for the doctors, we paid  
for the beds and the nurses -- we paid for everything.



1 with the result that in our second year of operation we  
2 were in debt \$20,000. So, we appealed to the Provincial  
3 Government and they took it over and are now conducting it,  
4 but they haven't the facilities. They haven't all the  
5 things mentioned to you in the various briefs, and the  
6 thing has to be attacked, it seems to me, from the very  
7 grass roots, from the people themselves. How can that  
8 intensive inoculation program be put into effect? I do  
9 not know whether it is within your Terms of Reference; I  
10 do not know whether this Commission can do anything in  
11 that direction, but our paragraph 12 -- and we have been  
12 endeavouring to do this in the Polio Foundation for some  
13 four of five years -- is that there ought to be an inten-  
14 sive program with leadership from the Federal Department  
15 of Health, through the Provincial Department of Health and  
16 through the municipal bodies, so that there can be a  
17 complete advertising program, complete facilities provided,  
18 to bring all the people to these centres and thereby  
19 remove this dread disease from our midst.

20 So, Mr. Chairman, if we have not given you  
21 a mass of figures, that is one of the reasons why.

22 It is true we are short of rehabilitation  
23 centres -- and I now introduce to you Mr. Fry, our Execu-  
24 tive Director. There is only one rehabilitation centre  
25 in the Province. We need a new one. There are now negotia-  
26 tions underway for the construction of one, but there is a  
27 shortage of money. We have never asked any Government  
28 for anything and we don't intend to ask for anything other  
29 than the general things in which we share. Two years ago  
30 with the co-operation of the Junior League of Canada --



1 with the... of...  
2 were in... 1947... we appeared to the...  
3 Government and they took it over and are now conducting it  
4 but they haven't the facilities. They haven't all the  
5 things mentioned to you in the various bulletins, and the  
6 thing has to be done... it seems to me, from the very  
7 grass roots, from the people themselves. You can't  
8 intensive... program as yet... I do  
9 not know whether it is within your terms of reference, I  
10 do not know whether the Government can do anything in  
11 that direction, but... is -- and we have been  
12 endeavoring to do this in the Public Foundation for some  
13 four or five years -- is that there ought to be an inter-  
14 sive program with... from the Federal Department  
15 of Health, through the Provincial Department of Health and  
16 through the municipal bodies, so that there can be a  
17 complete educational program, complete facilities provided,  
18 ...  
19 ...  
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29 ...





1 they provided \$3,000 and we provided \$5,000 -- we opened  
2 a shelter workshop and it is working exceedingly well.  
3 As a matter of fact, most of the briefs you have before  
4 you were mimeographed and printed in our shelter workshop.  
5 That is the thing we are doing, and the Junior League is  
6 coupled with it. We are happy to say at the last session  
7 of Parliament some aid is forthcoming for these shelter  
8 workshops. That is the only avenue through which we ask  
9 for Federal aid. What we ask throughout the whole of our  
10 submission is for something to remove what we think can  
11 be removed.

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/dpw 1 MR. FRY: My lord, ladies and gentlemen,  
2 while the subject of our brief, preventive medicine, is  
3 only a small part of your total enquiry, we feel it is a  
4 very important part. Prevention of disease is not only  
5 good public health; it is much less painful than treatment  
6 and a tremendous saving of public and private treasure.

7 For example, since the Salk vaccine has  
8 been in plentiful supply, there have been 3,300 cases of  
9 paralytic polio. The average cost for treatment and  
10 rehabilitation is \$10,000. We have, or will spend,  
11 \$33,000,000 just to treat and rehabilitate these cases,  
12 the vast majority of whom had had no vaccine. This sum  
13 of money is sufficient to vaccinate all the peoples of  
14 Canada and to pay the going rate for all services; and  
15 remember, this is not to mention the loss to the community  
16 of the earnings of these 3,300 people and the welfare costs  
17 for the maintenance of their dependants during the years  
18 they are being rehabilitated.

19 With the tremendous volume of research  
20 being carried on into the treatment and prevention of every  
21 known disease it is reasonable to assume in the not too  
22 distant future science will make available preventives  
23 for several other serious afflictions. We hope a lesson  
24 can be gained from the history of the Salk vaccine and  
25 effective plans made for direction and control to ensure  
26 preventive agents are not only available but are, in fact,  
27 used by every Canadian.

28 We hope, sir, the brevity of our brief will  
29 not obscure the seriousness of the problem we draw to your  
30 attention.



1. Mr. [Name], ladies and gentlemen,

2. It is the subject of our brief, preventive medicine, is  
3. only a small part of your total enquiry, we feel it is a  
4. very important part. Prevention of disease is not only  
5. good public health; it is much less painful than treatment  
6. and a tremendous saving of public and private resources.  
7. For example, among the Bala vaccine has  
8. been in preventive aspect, there have been 3,300 cases of  
9. paratyphoid fever. The average cost for treatment and  
10. rehabilitation is \$10,000. We have, or will need,  
11. \$35,000,000 just to treat and rehabilitate these cases.  
12. The vast majority of whom had had no vaccine. This sum  
13. of money in addition to vaccine and the salaries of  
14. guards and to pay the going rate for all services; and  
15. remember, this is not to mention the loss to the community  
16. of the earnings of these 3,300 people and the welfare costs  
17. for the maintenance of their dependants during the years  
18. that are being rehabilitated.

19. With the tremendous volume of research  
20. being carried on into the treatment and prevention of every  
21. new disease it is reasonable to assume in the not too  
22. distant future science will make available preventive  
23. for several other serious afflictions. We have a fever  
24. can be gained from the history of the Bala vaccine and  
25. effective plans made for detection and control to ensure  
26. preventive agents are not only available but are, in fact,  
27. used by every Canadian.  
28. We hope, Mr. [Name], the brevity of our brief will  
29. not obscure the seriousness of the problem we draw to your  
30. attention.



1 Mr. Chairman and members of the Royal  
2 Commission on Health Services:

3 1. We wish to address your Commission on  
4 the subject of Preventive Medicine. To illustrate the  
5 need we propose reviewing the history of the Salk vaccine  
6 in Nova Scotia and briefly in the whole of Canada.

7 2. In 1954, Nova Scotia participated in the  
8 field trials for this vaccine. In 1955, a limited program  
9 of "free" anti-polio vaccinations was instituted for  
10 school children in the schools and at the Public Health  
11 Clinics for pre-school children.

12 3. During the years 1955, 1956, and 1957,  
13 there was no policy of free vaccine for all residents of  
14 the Province, other than at the clinics referred to in  
15 para. 2.

16 4. During the years 1955 and 1956 commer-  
17 cial vaccine was in relatively short supply. Demand was  
18 very great.

19 5. During 1957 the supply position eased  
20 but the novelty of an anti-polio vaccine was supplanted  
21 by something else and there was very little demand.

22 6. In 1958, the Nova Scotia Chapter of the  
23 Canadian Foundation for Poliomyelitis made a careful study  
24 of the situation and decided to institute immediately a  
25 program to cover all age groups, and to provide clinics  
26 at each center of population at no cost to the person to  
27 be immunized. To ensure a large attendance at the clinics  
28 an intensive program of education was carried out.

29 7. At the cost of \$69,702.18, over two  
30 years, this program resulted in the administering of



Mr. Chairman and members of the Royal

1. We wish to discuss your Commission on

the subject of Preventive Medicine. To illustrate the

need we propose reviewing the history of the B.C. vaccine

in Nova Scotia and briefly in the rest of Canada.

2. In 1912, the first vaccination was carried out in the

field trials for this vaccine. In 1913, a limited program

of mass anti-polio vaccination was initiated in

school children in the schools and at the Public Health

3. There was no policy of free vaccine for all residents of

the Province, other than at the clinics referred to in

para. 2.

4. During the years 1955 and 1956 summer-

17. al vaccine was in relatively short supply. Demand was

5. During 1957 the supply position eased

but the novelty of an anti-polio vaccine was supplanted

by something else and there was very little demand.

6. In 1958, the Nova Scotia Chapter of the

Canadian Foundation for Polio Research made a request to the

of the association and decided to institute immediately a

7. To ensure a large attendance at the clinics

an intensive program of education was carried out

8. In the case of \$50,000.18, over the

years, this program resulted in the vaccination of





1 200193 c.cs of vaccine.

2 8. In 1959 the Province provided vaccine  
3 for all age groups at both public clinics and in doctors'  
4 offices.

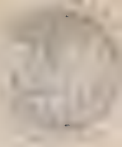
5 9. A review of reported cases of paralytic  
6 polio in Canada from the weekly returns of the Department  
7 of National Health and Welfare:

8	1955	520
9	1956	340
10	1957	257
11	1958	245
12	1959	1852
13	1960	820
14	1961	126

15 10. Interest in the vaccine waned as the  
16 incidence of paralytic polio decreased. In 1957 demand  
17 was so light that 1000000 c.cs of Canadian-manufactured  
18 vaccine were shipped to Czechoslovakia to prevent its out-  
19 dating and spoiling.

20 11. At the time of the epidemic of 1959 we  
21 saw a mad scramble for Salk vaccine. We saw all levels  
22 of Government and voluntary agencies "rediscover" Salk  
23 vaccine. We saw 1852 people paralyzed, most for life, and  
24 177 people die. Much of this suffering and terror was  
25 needless had the proper use been made of the vaccine in  
26 1956, 57, and 58.

27 12. We therefore recommend that there be  
28 no slackening, but rather an intensification, of a co-opera-  
29 tive effort among all governments with the firm purpose of  
30 providing immunization to all the people of Canada, by



117 cases of vaccine

for all age groups as with health clinics and in schools

9. A review of reported cases of paratyphoid

polio in Canada from the weekly reports of the Department

of National Health and Welfare:

1950 1951

1952 1953

1954 1955

1956 1957

1958 1959

1960 1961

For instance in the vaccine series as the

incidence of paratyphoid polio decreased, in 1957 demand

were dropped to decrease vaccine to prevent its use

attending and speaking

11. At the time of the epidemic of 1959 we

saw a mad scramble for Salk vaccine. We saw all levels

vaccine. We saw 1959 people paralyzed, most for life, and

177 people die. Part of this suffering and terror was

needed and the vaccine was then made of the vaccine in

2, 5, and 10.

12. We therefore recommend that there be

no stock pile, but rather an immediate reaction to a shortage

five billion among all governments with the aim purpose of

preventing the spread of paratyphoid



1 such scientific procedures as the authorities determine.  
2 In this effort we respectfully suggest that the Federal  
3 Department of Health should give the major guidance and  
4 direction.

5 13. We regret that we are unable to provide  
6 concrete proposals, directives to action, or estimates of  
7 cost, because we cannot know with sufficient sureness which  
8 of the many research projects will produce effective  
9 preventives. The means of transmission of the agent will  
10 govern the program and the public education plan can only  
11 be devised after a program has been agreed upon.

12 THE CHAIRMAN: Thank you very much, gentle-  
13 men.

14 I think that I may be permitted to say that  
15 this is the last submission that we will be receiving here,  
16 the last one on our agenda, and I think it is most fitting  
17 that it should be presented in such an exceedingly able  
18 and forceful manner and to finish up on such a hopeful  
19 outlook that you are able to say with proper immunization  
20 we may do away with the disease entirely. Thank you very much.

21 THE SECRETARY: Mr. Chairman, could the last  
22 submission be known as Exhibit 20?

23 THE CHAIRMAN: Yes.

24  
25 --- EXHIBIT NO. 20: Submission of the Canadian Foundation  
26 for Poliomyelitis and Rehabilitation,  
27 Nova Scotia Chapter

28 THE CHAIRMAN: Now, ladies and gentlemen,  
29 members of the Commission, as I indicated, this concludes  
30 the hearings of the submissions of which we had notice



of Health should give the major evidence and

13. We regret that we are unable to provide  
concrete proposals, directives to action, or estimates of  
cost, because we cannot know with sufficient accuracy which  
of the many research projects will produce effective  
preventives. The means of transmission of the agent will  
govern the program and the public education plan can only  
be devised after a program has been worked out.  
THE CHAIRMAN: Thank you very much, ladies-

14 Mrs.

I think that I may be permitted to say that  
this is the last submission that we will be receiving here  
the last one on our agenda, and I think it is most fitting  
that it should be presented in such an exceedingly able  
and forceful manner and so I think up to such a report  
that you are able to say with proper justification  
we may do away with the disease completely. Thank you very much.

THE SECRETARY: Mr. Chairman, could we last

submission be known as Exhibit 20?

--- EXHIBIT NO. 20: Submission of the Canadian Foundation  
for Polio Research and Rehabilitation

THE CHAIRMAN: Now, ladies and gentlemen,

members of the Commission, as I indicated, this concludes  
the hearings of the submissions of which we had notice



1 and from all who had indicated a desire to be heard at  
2 these hearings here in Halifax.

3           Before we close, I want, on behalf of the  
4 Commission, and at their request, at the request of the  
5 individual members, and on my own behalf, to express our  
6 thanks to Premier Stanfield, to the Honourable Mr. Donahoe,  
7 to the officials in connection with this building, who  
8 have made our inquiry here in Halifax a very fruitful one  
9 and under the most pleasant circumstances. The quality  
10 of the submissions which we have received have been of a  
11 high order, they have given much information and the  
12 promise of additional information which will be very  
13 valuable to the Commission in its ultimate deliberations.

14           So as we close this hearing, I want to  
15 express the gratitude of the Commission to the Government,  
16 to His Worship the Mayor and to all who have assisted the  
17 Commission in what I am happy to call, a very fruitful  
18 hearing. Thank you.

19  
20 --- Whereupon the hearing adjourned until Thursday,  
21 November 2nd, 1961, at St. John's, Newfoundland.

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1 and from all who had indicated a desire to be heard at

2 Before we close, I want, on behalf of the

3 Commission, and at their request, at the request of the

4 individual members, and on my own behalf, to express our

5 thanks to President Stansfield, to the Honorable Mr. Donahoe

6 to the officials in connection with this building, who

7 have made our hearing here in Halifax a very fruitful one

8 and under the most pleasant circumstances. The quality

9 of the submissions which we have received have been of a

10 high order, they have given much information and the

11 provision of additional information which will be very

12 valuable to the Commission in its ultimate deliberations.

13 As we close this hearing, I want to

14 express the gratitude of the Commission to the Government,

15 to His Worship the Mayor and to all who have assisted the

16 Commission in what I am happy to call, a very fruitful

17 hearing. Thank you.

18 -- When you are being adjourned until Thursday.

















